[H.A.S.C. No. 111–60]

HEARING

ON

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2010

AND

OVERSIGHT OF PREVIOUSLY AUTHORIZED PROGRAMS

BEFORE THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

MILITARY PERSONNEL SUBCOMMITTEE HEARING

ON

BUDGET REQUEST ON DEFENSE HEALTH PROGRAM OVERVIEW

HEARING HELD
MAY 15, 2009

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HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Friday, May 15, 2009.

The subcommittee met, pursuant to call, at 9:00 a.m., in room 2118, Rayburn House Office Building, Hon. Susan A. Davis (chairwoman of the subcommittee) presiding.

OPENING STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, MILITARY PERSONNEL SUBCOMMITTEE

Mrs. DAVIS. Good morning. Today's hearing is on the Department of Defense's fiscal year 2010 budget for the Defense Health Program.

For the first time in three years, the Department of Defense (DOD) has not proposed massive TRICARE fee increases as part of their budget request. The increases proposed in previous years would have provided large savings for the Department, but most of the savings would have been the result of raising fees so high that large numbers of beneficiaries would choose to leave the system. We are encouraged that the Department has not chosen to pursue that course of action this year.

The Secretary of Defense has said that his intent was to fully fund military health care in the fiscal year 2010 budget and then engage Congress in a dialogue about what comes next. We will obviously have to wait to start that conversation until the President's appointees are in place, but we look forward to the discussion this committee has been trying to have with the Department for years. Our beneficiaries deserve no less.

We must now closely examine the budget proposal to see if it is, indeed, fully funded. I should mention that we have only had the budget justification materials for about the last 36 hours and are still awaiting answers from the Department on various issues. It would be helpful if our witnesses could offer any insights they may possess on how certain amounts were chosen and how various decisions were made.

During our annual reviews of the Defense Health Program (DHP) budget, we always ask questions about how the proposed budget will support our deployed service members and their families. In light of recent events, we will undoubtedly focus additional attention on how this proposed budget will improve mental health

services, as well as any unfunded mental health requirements the services may have.

For our witness panel, we have the Acting Principal Deputy Assistant Secretary of Defense for Health Affairs, Mr. Allen Middleton, representing the Office of the Secretary of Defense. Until recently, Mr. Middleton was the Acting Deputy Assistant Secretary of Defense for Health Budget and Financial Planning.

So we know, sir, that you will be able to answer our budget questions in great detail.

We also have all the service surgeon generals: Lieutenant General James Roudebush, from the Air Force; Vice Admiral Adam Robinson, from the Navy; and Lieutenant General Eric Schoomaker, from the Army.

General Roudebush, I understand that you will be retiring in August, and we really appreciate all of your service. We want to thank you for the quiet determination with which you have led the Air Force Medical Service and the unwavering commitment that you have displayed for our men and women in uniform. Thank you very much, sir.

General ROUDEBUSH. Thank you, ma'am.

Mrs. DAVIS. You will be missed, and we wish you well in your future endeavors.

And now I will turn to Mr. Wilson for his opening comments.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 35.]

STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, RANKING MEMBER, MILITARY PERSONNEL SUBCOMMITTEE

Mr. WILSON. Thank you, Chairwoman Davis.

Today, the subcommittee meets to hear testimony on the Defense Health Program, DHP, for fiscal year 2010. Although we routinely have an annual hearing on the DHP, I want to emphasize that there is nothing routine about the Military Health System and the extraordinary care it provides to our service members around the globe and their families.

This subcommittee remains committed to ensuring that the remarkable men and women who are entrusted with the lives of our troops have the resources to continue their work for future generations of our most deserving military beneficiaries. I would like to express my deep appreciation to all of the Military Health System (MHS) leadership and personnel who are responsible for delivering the highest-quality health care during these most challenging times.

To begin, I want to commend the Department of Defense for sending us, for the first time in four years, a fully funded budget for the Defense Health Program. I applaud Secretary Robert Gates for hearing what Congress and our military beneficiaries have said repeatedly: Increasing TRICARE fees is not the solution for containing the rising costs of military health care.

With that, I am anxious to hear from our witnesses today how the Department plans to develop a comprehensive approach to providing world-class health care to our beneficiaries while, at the same time, controlling costs. I look forward to working with the

leadership of the Military Health System toward that end. I would also like to hear your commitment that all of the stakeholders in the military health care will be involved in the process.

I am interested in hearing from the witnesses how the DHP supports the critical mental health services needed by our service members and their families, particularly the National Guard and Reserve members, who rely primarily on TRICARE Standard.

I would like to hear from our military surgeon generals whether the DHP will fully support their responsibility to maintain medical readiness, provide health care to eligible beneficiaries, provide battlefield medicine to our brave men and women in Iraq and Afghanistan in the Global War on Terrorism, and care for those brave men and women through the long recovery process when they become injured and wounded.

And, as we conclude, I want to join with Chairwoman Davis and commend General Roudebush on his service.

And thank you very much, and we wish you well and a long, healthy, and happy retirement.

General ROUDEBUSH. Thank you, sir.

Mr. WILSON. With that, I would like to welcome our witnesses and thank them for participating in the hearing today. I look forward to your testimony.

[The prepared statement of Mr. Wilson can be found in the Appendix on page 37.]

Mrs. DAVIS. Thank you, Mr. Wilson.

I also wanted to introduce Mr. Charles Campbell, chief information officer for the Military Health System, Office of the Assistant Secretary of Defense for Health Affairs, the Department of Defense.

Thank you very much, sir, for being here.

And I will start with some questions, and hopefully, you know, we might end up with a real dialogue today because, as you know, Members went back to their districts, and so we have fewer Members today.

Mr. Middleton, Mr. Campbell, back in March, we, along with the Subcommittee on Terrorism and Unconventional Threats and Capabilities, held a joint hearing on the Department of Defense's health information technology systems. And at that hearing, we heard from the services about the difficulties they had faced with Armed Forces Health Longitudinal Technology Application (AHLTA). We were encouraged to hear from Health Affairs that you agree that there are serious problems and even more encouraged when you presented what appeared to be an ambitious and comprehensive plan to overhaul the system to address all of the issues raised by the services and provide the best health information technology (IT) system possible for the Department's beneficiaries.

At that hearing—I am starting to ask you questions before you make your presentation, but maybe I will do that and you can start trying to incorporate them, if you will? Okay?

Or maybe not. Let's go ahead. Let's just start the hearing with your presentations, and then we will get to our questions. I am so eager to ask that question. But it is important to hear from you first.

If you want to address the IT question, you can, but we will come back to it and come back to a number of other questions. As I mentioned, mental health is certainly on our minds, and we know that there are a number of issues that you really want to share with us, as well.

So let's begin with Mr. Middleton. Thank you.

STATEMENTS OF ALLEN W. MIDDLETON, ACTING PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE; LT. GEN. ERIC B. SCHOOMAKER, USA, COMMANDING GENERAL, U.S. ARMY MEDICAL COMMAND, THE SURGEON GENERAL, U.S. ARMY; VICE ADM. ADAM M. ROBINSON, USN, SURGEON GENERAL, U.S. NAVY; LT. GEN. JAMES G. ROUDEBUSH, USAF, SURGEON GENERAL, U.S. AIR FORCE; AND CHARLES CAMPBELL, CHIEF INFORMATION OFFICER, MILITARY HEALTH SYSTEM, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

STATEMENT OF ALLEN W. MIDDLETON

Mr. MIDDLETON. Thank you, Madam Chairman, members of the committee. Thank you for this opportunity to discuss the priorities of the Military Health System and its budget for fiscal year 2010. We are pleased to be here.

The men and women of America's Armed Forces are our country's greatest strategic asset. And apart from defending the Nation, the Department has no higher priority than to provide the highest quality and support to our forces and, of course, their families.

As Secretary Gates has said, at the heart of the All-Volunteer Force is the contract between the United States of America and the men and women who serve, a contract that is legal, social, and sacred. When young Americans step forward on their own free will to serve, he said, they do so with the expectation that they and their families will be properly taken care of.

Indeed, the Military Health System has one overarching mission: to provide optimal health services systems in support of our Nation's military mission anytime and anywhere. Today, the Military Health System serves 9.4 million beneficiaries: active duty, their family members, our retired military members and their families.

In addition to force health protection and family support, the MHS provides humanitarian assistance at home and around the world and supports world-class education, training, and research.

Our strategic plan, developed in concert with the surgeon generals and the joint staff, supports all of these three component missions. It also recognizes the outcomes the American people expect from their investment in military medicine. In addition to a fit, healthy, and protected force, our goals include the lowest possible rate of death, injury, and disease during military operations; superior follow-up care that includes transition to the Department of Veteran Affairs; healthy and resilient individuals, family and communities; and the high-quality, cost-effective care our Nation expects.

We appreciate deeply the support that Congress, especially this committee, has provided to us to help deliver the very best health

care for our forces and their families, and in particular for our wounded, ill, and injured. I believe we have made significant progress toward each of these goals.

And I have provided this information in considerable detail in my submitted written statement to you. For now, let me briefly summarize the uniform medical budget request for 2010.

The Department's total request for health care in fiscal year 2010 is $47.4 billion, including the Defense Health Program; the wounded, ill, and injured for rehabilitation; military personnel; military construction; and contributions to the Medicare-Eligible Retiree Health Care Fund.

The largest portion of our budget, almost $28 billion, is requested by the Defense Health Program for operations and maintenance, procurement, research and development, test and evaluation. $0.3 billion is requested for equipment and systems procurement; $0.6 billion is requested for military-relevant medical research; and $0.4 billion to improve survivability and quality-of-life issues.

For military personnel, the budget request is $7.7 billion to support more than 84,000 military personnel who provide the mental health care services to our deployed forces around the world, including aeromedical evacuation, shipboard and undersea medicine, and global humanitarian assistance and response.

Funding for military construction is at $1 billion in fiscal year 2010 for 23 construction projects, including phase one of the replacement at Guam and for an ambulatory care center at Lackland Air Force Base, Texas.

In the Medicare-Eligible Retiree Health Care Fund, the fund which supports the TRICARE for Life program, our estimated normal cost contribution this year is just under $11 billion.

For our wounded, ill, and injured members, the 2010 DHP budget includes $1.7 billion for enhanced care as well as research efforts to mitigate the effects of psychological health and traumatic brain injury.

All of the requirements of both the service medical departments and the TRICARE management activity were funded by the Secretary, and we do not anticipate any additional requirements at this time.

You will be interested to know that this budget does not include any benefit reform savings, as you mentioned, with beneficiary enrollment fee or co-pay increases, and they remain the same.

The military treatment facility (MTF) efficiency wedge previously assumed has also been fully restored to the services' medical departments. And the previously programmed military-to-civilian conversions are being restored in accordance with the fiscal year 2008 National Defense Authorization Act, and that restores just under 5,500 billets in 2010.

Madam Chairman, the Military Health System is dedicated to doing the very best we can for the men and women who give everything they have for each one of us. We can never fully repay them for the sacrifices they make for our country and for our future, but we can and will continue to do everything we can to heal their wounds and to honor their courage and commitment to the country that we all love.

Thank you again for this opportunity with you, and we do look forward to your questions.

[The prepared statement of Mr. Middleton can be found in the Appendix on page 38.]

Mrs. DAVIS. Thank you very much.

General Schoomaker.

STATEMENT OF LT. GEN. ERIC B. SCHOOMAKER

General SCHOOMAKER. Madam Chairwoman, Representative Wilson, and other distinguished members of the Military Personnel Subcommittee, thank you for the opportunity to discuss Army Medicine and the Defense Health Program today.

In recognition, again, that 2009 is our year of the non-commissioned officer (NCO) in the Army, I am joined today by my senior enlisted medic and my battle buddy, Command Sergeant Major Althea Dixon. And she is my constant reminder that our NCO corps really is what makes Army and Army Medicine strong.

What distinguishes military and Army Medicine from U.S. health care as a whole is our commitment to improving and sustaining the health of the force as a strategic imperative. On the Army strategy map that was a part of the packet that you all received, we used a Kaplan and Norton-developed Harvard Business School balanced score card approach to both leadership and management of Army Medicine.

We have included two of our six strategic goals, or ends, that highlight the improved health and protection of our personnel, be they warriors or families or beneficiaries or civilians. The health of the force, and by extension that of our families and all of our beneficiaries, is a national asset. It is heightened by our reliance on an All-Volunteer Force. I will say that again: Our reliance on an All-Volunteer Force especially has pushed us toward an increased focus upon keeping the force healthy and able to be mission-focused from the beginning.

In order to make the assertion that we are a system of health, as opposed to a health care system, delivering health care alone, that we are a system of health, we have taken several key actions.

First, we stay focused at a corporate level on optimizing health through evidence-based practices, which raise our markers of future care, or proxies I call them, of current and future health, like vaccination rates or compliance with the United States Preventive Services Task Force guidelines for screening, and our Healthcare Effectiveness Data and Information Set, or HEDIS, measures. These are population health improvement and evidence-based practices which are being uniformly applied across U.S. medicine but especially within the Military Health System.

A second issue or approach is by resourcing our commands to effect these population health outcomes and permit the generation of revenue, which encourages these and other best practices aimed at raising the health of the beneficiary population. This is different than much of American medicine, where preventative measures in optimizing health is not well-reimbursed and resourced. We have shifted our revenue stream increasingly toward optimization of health.

Third, we have moved toward maintaining strong links to like agencies and organizations which foster and reduce risky behaviors that enhance evidence-based practices and promote healthy lifestyles, the Department of Veterans Affairs (VA) being among them.

We establish programs and partnerships which protect the health of the population through shared health surveillance, through the prevention of epidemic disease, enhanced food and water safety, enhanced resilience of the force, and the like.

Army Medicine is currently reviewing options for developing a public health command within the Army, where we have a single focus of public health within the Army from all of those who contribute to that, whether they be veterinarians, public health officers, nurse community health workers, or the like. I think it would be beneficial to the Army and our soldiers to create a single point of expertise and responsibility for public health.

These and other examples demonstrate that Army and military medicine—I am joined by my colleagues—are increasingly a system for health in every regard raised, from increasing HEDIS measures, to a health-focus performance-based budgeting process, to the development of the Army comprehensive soldier fitness initiative where we build resilience and the physical, emotional, intellectual, spiritual fitness in response—and it is illustrated by our response to H1N1 flu this year and our stance against future bio threats.

It is one significant aspect of how military medicine is different from civilian medical organizations and why we cannot be compared entirely to civilian medicine. I strongly believe that we must focus on building and maintaining health and resilience and in conducting science-based, evidence-based practices focusing on optimal clinical outcomes when bad things happen to good people and they fall off this balance beam of health. That happens in combat; it happens with serious disease and injury.

I believe—and you all posed this question—I believe that this approach will ultimately lead to the best results both for the Army and the military community, and it will deliver the most cost-effective system of health and health care. Focus on evidence-based practices, on health and on outcomes.

Another striking difference between military and civilian medicine is our Wounded Warrior mission. It is an inherent—there are inherent, operationally driven inefficiencies involved in the delivery of care to this complex population of warriors in transition.

On a per capita basis, the care of wounded, ill, and injured soldiers, or what we call Warriors in Transition, consume upwards to six times as much health care resources as a healthy population. Now, you see this when you go to our military hospitals in our Warrior Transition Units (WTU), where we have placed some of the talented officer and NCO leaders and where nurses and physicians and occupational therapists, physical therapists, behavioral health providers and many others combine their expertise in an intense effort to recover and rehabilitate and transition and reintegrate these great warriors and care for their families.

The intensity of care delivered to these almost now 10,000 warriors is not comparable in any other civilian setting. These Warriors in Transition deserve every bit of the care and attention, as mentioned earlier by my colleague, from Health Affairs. But I raise

this as another example of the uniqueness of Army and military medicine. It is not replicated in the civilian setting, and it probably never will be because of expertise and cost inefficiencies in running such a program.

Finally, let me just comment—as you asked, ma'am, and you, sir—about our efforts to prevent, mitigate, identify, manage, and treat behavioral health consequences of service in uniform and those arising from frequent deployments, long family and community separations, and exposure to the rigors of combat.

Army leaders at all levels recognize that combat and repeated deployments are difficult for soldiers and they stress our families. We are making bold, sustained efforts to improve the resilience of the entire Army and its family, to reduce the stigma associated of seeking mental health care, and to provide multidisciplinary care which addresses specific behavioral and health needs promptly and expertly.

We are resolved to prevent adverse social outcomes associated with military service and combat, such as driving while intoxicated and family violence and other such misconduct.

Suicides are unacceptable losses of our soldiers. Realizing that the loss of even one soldier to suicide is one too many, we are looking closely at factors involved. And rather than post-traumatic stress disorder, as one might expect, we continue to see that fractured relationships and work-related stresses are the major factors in soldier suicides. We have numerous coordinated and integrated initiatives in place to help soldiers and their families. I am eager to discuss these and any other issues in this realm that you wish to address.

In closing, I want to thank again the committee for their terrific support of the Defense Health Program and of Army Medicine.

As I close, I would like to salute our non-commissioned officers for their professionalism and competence and leadership.

And, ma'am and sir, I am pleased that you recognized my colleague, our colleague, Jim Roudebush, as he gets ready to depart a long and distinguished service in Air Force Medicine. He embodies, really, a scholarly wisdom, unflappability, and experience. And he has really taught us what being a wingman is.

And what we are very pleased with is, as he leaves service, he leaves a son in an Army uniform in a Stryker Brigade in Fort Lewis, Washington. And so I will close by saying, "Army strong and air power."

[The prepared statement of General Schoomaker can be found in the Appendix on page 57.]

Mrs. DAVIS. Thank you very much.

Admiral Robinson.

STATEMENT OF VICE ADM. ADAM M. ROBINSON

Admiral ROBINSON. Good morning. Chairwoman Davis, Congressman Wilson, distinguished members of the committee, thank you for the opportunity to be here this morning.

Navy Medicine continues on course because our focus has been and will always be providing the best health care for our sailors, Marines, and their family members while supporting our Nation's overseas contingency operations.

As Admiral Mullen pointed out earlier this week, the Navy is doing a lot more than most people know about. Navy Medicine is meeting the mental and physical needs of our service members abroad and preparing healthy and fit sailors and Marines to protect our Nation and deploy.

We are continuously making the necessary changes and improvements to meet the requirements of the biggest consumer of our operational support efforts, the Marine Corps. Currently, we are realigning medical capabilities to support operational forces in emerging theaters of operation. Navy Medicine's combat medical support has proven exceptionally successful, and we will sustain and improve those efforts in the future.

The Navy's humanitarian and civil assistance missions are increasing, and this year, our efforts will include missions in the U.S. Southern and Pacific Command areas of operation.

As previously announced, our plans included deploying the USS *Dubuque* (LPD 8) later this year as part of the Pacific Partnership 2009. However, an outbreak of H1N1 influenza among the ship's crew has altered those plans. We are actively engaged in finding alternative ways to deliver medical care to these nations and ensuring the medical care provided positively impacts the perception of the United States and our allies by other nations.

I would like to take this opportunity to point out that, although the operational portion of our humanitarian missions are funded by the Navy's Fleet Forces Command, Navy Medicine is not afforded any credit for the work performed during these critical missions. In fiscal year 2008, Navy Medicine deployed medical providers in support of worldwide missions. These providers had almost 130 outpatient and over 1,100 inpatient encounters worldwide. We are also taxed in our direct-care reimbursement funding as part of the Health Affairs pay-for-performance calculations.

I also remain concerned about how the increases in private-sector care costs will be addressed, as the care we provide in our medical treatment facilities must be preserved in order to meet our dual mission of operational support and beneficiary health care. Growing resource constraints for Navy Medicine are real, as is the increasing pressure to operate more efficiently without compromising health care quality and workload goals. We continue to make improvements to meet the needs of sailors and Marines who have been injured and have significantly expanded services so wounded warriors have access to timely, high-quality medical care.

Navy Medicine's concept of care is patient- and family-focused. We never lose our perspective in caring for our beneficiaries. Everyone is a unique human being in need of individualized, compassionate, and professionally superior health care.

As of May 2009, 171 medical case managers were assigned to 45 medical treatment facilities and ambulatory care clinics, caring for approximately 1,500 Operation Enduring Freedom/Operation Iraqi Freedom casualties. The medical case care managers collaborate with Navy Safe Harbor and Marine Corps Wounded Warrior Regiment and new programs, such as Families Overcoming Under Stress, FOCUS, in working directly with our beneficiaries, our wounded warriors, their families and caregivers, and the multi-

disciplinary medical team to coordinate the complex services needed for improved health outcomes.

The Bureau of Medicine and Surgery (BUMED) Wounded Warrior Regiment Medical Review team and the Returning Warrior Workshops support Marines and Navy sailors, reservists, and their families by focusing on key issues faced by personnel during their transition from deployment to home.

Navy and Marine Corps liaisons at medical treatment facilities aggressively ensure that orders and other administrative details, such as extending reservists, are completed. In addition, we recently hired 25 psychological outreach coordinators to identify and meet the mental health needs of our reservists.

Navy Medicine has also partnered with Navy and Marine Corps communities to identify specific populations at risk for traumatic brain injury in frontline units, such as SEALs (Sea, Air, Land) and Navy Explosive Ordnance Disposal Units.

Navy Medicine's innovative deployment health centers, currently in 17 high fleet and Marine Corps concentration areas, supports the deployment health assessment process and serve as easily accessible and nonstigmatizing portals of entry for our forward mental health care. Since their establishment in 2007, the centers have accomplished over 150,000 health care encounters, with about 23 percent for psychological health issues. This further demonstrates our expanded efforts where primary care providers are addressing the mental health needs of our sailors and Marines, as we continue to expand our operational stress and resiliency programs from boot camp through war college.

Navy Medicine's partnership with the Department of Veterans Affairs' medical facilities continues to be mutually beneficial. This coordinated care for our warriors who transfer to or are receiving care from a VA facility ensures their needs are met and their family concerns are addressed.

Working closely with the Chief of Navy Personnel, medical recruiting continues to be one of our top priorities. And we thank Congress for their generous support of our medical special pay and bonus authority.

In spite of the successes in medical and dental corps recruitment into our scholarship programs, meeting our direct accession mission still remains a challenge. I anticipate increased demand for Medical Service Corps personnel, our most diverse corps with 31 specialties. This is especially true among Medical Services Corps specialties linked to mental, behavioral, and rehabilitative health and operational support, such as clinical psychologists, social workers, occupational therapists, physician assistants, and physical therapists.

Consistent with increased operational demand signals, as well as to compensate for prior shortfalls in recruiting, the overall recruiting call for the Uniformed Medical Service Corps officers have nearly doubled since fiscal year 2007. For the first time in over five years, Navy Nurse Corps officers gained in 2008 outpaced losses. Despite the growing national nursing shortage and the resistance of the civilian nursing community to recession, the recruitment and retention of Navy nurses continues to improve.

Chairwoman Davis, Congressman Wilson, I would like to take this opportunity to offer my deep condolences to the Springle family and the families of the other victims of this week's tragic events at Camp Liberty in Iraq. Commander Springle was a Navy social worker serving with the Army's 55th Medical Company as an individual augmentee.

I would also like to extend my congratulations to Jim Roudebush on being a wonderful shipmate, wingman, a wonderful partner in this military health establishment that we have here, and someone that was always dependable, both as a professional and as a friend.

Thank you again for providing me the opportunity to testify, and I look forward to answering your questions.

[The prepared statement of Admiral Robinson can be found in the Appendix on page 81.]

Mrs. DAVIS. Thank you, Admiral.

And, General Roudebush, if you would continue. And obviously you have been a tremendous mentor and colleague to many that you served with. And we thank you again.

STATEMENT OF LT. GEN. JAMES G. ROUDEBUSH

General ROUDEBUSH. Madam Chairwoman, Congressman Wilson, thank you for the very kind thoughts you have expressed, and certainly those of my colleagues. I will tell you, it is a privilege to serve, but as I move to the next chapter, each of us who serves may stop wearing the uniform but we never take it off and we continue to serve. And I look forward to that. Thank you, ma'am.

It is a pleasure to be here today to talk to you about the Air Force Medical Service. Air Force Medicine contributes significantly to our joint capability as part of a joint team in the joint war-fight, serving those men and women in harm's way and serving our Nation with combat casualty care, wartime surgery, and aeromedical evacuation.

On the ground, at both the Air Force Theater Hospital in Balad, Iraq, and the SSG Heath N. Craig Joint Theater Hospital in Bagram, in Afghanistan, we are leading numerous combat casualty care initiatives that will positively impact combat and peacetime medicine for years to come.

Air Force surgeons have laid the foundation for a state-of-the-art intervascular operating room at Balad, the only DOD facility of its kind. Their innovative technology and surgical techniques have greatly advanced the care of our joint war-fighters and coalition casualties. And in conjunction with our Army and Navy brothers and sisters, they have literally rewritten the book on the use of blood in trauma resuscitation.

To bring our wounded warriors safely and rapidly home, our Critical Care Air Transport Teams, our CCATTs, provide a unique intensive care unit (ICU) care in the air within DOD's joint en route medical care system. We continue to improve the outcomes of the care of our CCATT wounded warriors by incorporating lessons learned in clinical practice guidelines and modernizing equipment to support that mission.

This Air Force-unique expertise also pays huge dividends back home. When Hurricane Katrina and Rita struck in 2005, Air Force active-duty Guard and Reserve medical personnel were in place

conducting lifesaving operations. Similarly, hundreds of members of this total force team were in place September 1st, 2008, when Hurricane Gustav struck the Louisiana coast and when Hurricane Ike battered Galveston, Texas, less than two weeks later. During Hurricane Gustav, Air Mobility Command coordinated the movement of more than 8,000 evacuees, including 600 patients. Air crews transported post-surgical and intensive care patients from Texas area hospitals to Dallas. I am extremely proud of this incredible team effort.

The success of our Air Force mission directly correlates with our ability to build and maintain a healthy and fit force at home station and in theater. Always working to improve care, our Family Health Initiative establishes an Air Force medical home. This medical home optimizes health care practice within our family health care faculties and clinics, positioning a primary care team to better accommodate the enrolled population and streamline the processes for care and disease management. The result is better access, better care, and better health.

The psychological health of our airmen is also critically important. To mitigate their risk for combat stress symptoms and possible mental health problems, our program known as Landing Gear takes a proactive approach with education and symptom recognition, both pre- and post-deployment. We educate our airmen that recognizing risk factors in themselves and others, along with a willingness to seek help, is the key to effectively functioning across the deployment cycle and reuniting and reintegrating with their families. Likewise, we screen very carefully for traumatic brain injury at home and at our forward-deployed locations.

To respond to airmen's needs, we have over 600 active-duty and 200 civilian and contract mental health providers. This mental health workforce has been sufficient to meet the demand signal that we have experienced to date. That said, we do have challenges with respect to active-duty psychologist and psychiatrist recruiting and retention. And we are pursuing special pays and other initiatives to try to bring us closer to 100 percent staffing in these two critically important specialties.

For your awareness, over time we are seeing an increasing number of airmen with post-traumatic stress disorder (PTSD). One thousand seven hundred fifty-eight airmen have been diagnosed with PTSD within 12 months of return from deployment from 2002 to 2008. As a result of our efforts at early post-traumatic stress identification and treatment, the vast majority of these airmen continue to serve with the benefit of treatment and support.

Understanding that suicide prevention, as well, lies within and is integrated into the broader construct of psychological health and fitness, our suicide prevention program, a community-based program, provides the foundation for our efforts. Rapid recognition, active engagement at all levels, and reducing any stigma associated with seeking help are hallmarks of our program. One suicide is too many, and we are working hard to prevent the next.

Sustaining the Air Force Medical Service requires the very best in education and training for our professionals. In today's military, that means providing high-quality programs within our system, as well as strategically partnering with academia, private-sector medi-

cine, and the VA to ensure that our students, residents, and fellows have the best training opportunities possible.

While the Air Force continues to attract many of the finest health professionals in the world, we still have significant challenges in recruiting and retention. We are working closely with our personnel and recruiting communities, using accession and retention bonus plans to ensure full and effective staffing with the right specialty mix to perform our mission.

At the center of our strategy is the Health Profession Scholarship Program (HPSP). HPSP is our most successful recruiting tool, but we are also seeing positive trends in retention from our other financial assistance programs and pay plans. Thank you for your unwavering support in helping us both establish and fund those programs.

In summary, Air Force medicine is making a difference in the lives of airmen, soldiers, sailors, Marines, family members, coalition partners, and our Nation's citizens. We are earning their trust every day.

As we look forward to the way ahead, I see a great future for the Air Force Medical Service, built on a solid foundation of topnotch people, outstanding training programs, and strong partnerships. It is indeed an exciting, challenging, and rewarding time to be in Air Force and military medicine. I couldn't be more proud of this great team.

We join our sister services in thanking you for your enduring support, and I look forward to your questions.

[The prepared statement of General Roudebush can be found in the Appendix on page 94.]

Mrs. DAVIS. Thank you, General.

As I started to ask you earlier about the health IT system, this is obviously something that is of great concern. Going back to March, along with the Subcommittee on Terrorism and Unconventional Threats and Capabilities, this committee held a joint hearing on the Department of Defense's health information technology systems. And we heard from the services about the difficulties that they were really having with the AHLTA system.

We were encouraged to hear from Health Affairs that you agree that there are serious problems, and even more encouraged when you presented what appeared to be an ambitious and comprehensive plan to overhaul the system to address all the issues raised by the services and provide the best health IT system possible for the Department's beneficiaries.

And at that particular hearing, Dr. Casscells and you also, Mr. Campbell, assured us that you were committed to moving forward with your proposed solution but that you could not discuss cost details because both the fiscal year 2009 supplemental request and the fiscal year 2010 budget were still in progress.

But now that we have received the 2010 budget justification materials, we can't seem to find any mention of any of the promises that you made during the March hearing. And a review of the fiscal year 2009 supplemental request did not turn up any mention of that plan either. So, as you can imagine, we are trying to understand that.

And sometimes this kind of conflict is not really unprecedented. During preparation of last year's National Defense Authorization Act, Mr. Campbell, you and Dr. Casscells both assured us, during a Member briefing, that you were aware of the problems with AHLTA and would provide us with a plan to fix the problems.

And following that meeting, Health Affairs provided us with a roadmap for the way ahead. But, again, none of the elements of that roadmap ever found their way into either the 2008 supplemental request or fiscal year 2009 budget request at that earlier period. And so, we have some concern that things are not moving forward.

Could you please share with us what is going on? What is happening in the decision-making around the issue? And when will we see some fulfillment of the commitments that were made to the committee back in March?

Mr. CAMPBELL. Yes, ma'am. Thank you for the question.

Going back to the 2007 discussion that we had, as you mentioned, it wasn't in the budget for that year. What we did, though, is, within the budget that we had, we focused our efforts to meet the requirements of the theater health information systems that were——

Mrs. DAVIS. If you could get a little closer to the mike. Thank you.

Mr. CAMPBELL. Sorry, ma'am.

So we focused that year, in 2008, and part of also 2009, we continued to focus our efforts on the theater health systems. And within our budget at that time—we didn't ask for additional dollars, but within our budget at that time we implemented that services-oriented architecture approach that we had talked about for doing the larger-scale system and have made some great improvements in that, in setting up that application or that system that allows us to more quickly develop capabilities for the users and to allow us to more seamlessly share that information across DOD and across the VA. So that was implemented over last year, in 2008, and we are still working that in 2009 within our current budget.

You are absolutely right in that, when we were here in March, we had a very comprehensive plan. We still have that comprehensive plan. It wasn't complete at that time. I think we mentioned that at the end of March was when the blueprint was going to be finished. The blueprint was finished and turned in. And we are in discussions right now on how we are going to implement that within the current budget.

So we are doing things to improve the systems now with our current baseline. For example, one of the key components that the services and others have mentioned to us is maintaining the stability of the system. A key to that stability is our one central data repository that we have where all of the information is stored. If, for some reason, that goes down and is not working, then everyone goes into a failover mode.

So we have focused some efforts recently, within the last two months, on stabilizing the central data repository so that we can keep it up and running. And we have made some good improvements on that.

Mrs. DAVIS. Mr. Campbell, could you identify the dollars that you have available to you to do this work?

Mr. CAMPBELL. Within our current budget?

Mrs. DAVIS. Yes.

Mr. CAMPBELL. Yes, ma'am. Within our current—I think it is the 2009 budget, I think for the total electronic health record system in our current budget, I believe it is around $500 million, in our current budget for 2009, for all parts, all components of the electronic health records system. That includes the infrastructure piece, that includes the central data repository, the old legacy system, Composite Health Care System (CHCS).

A lot of that money is used to sustain our current efforts, but it also has some dollars in there for development and for procuring new equipment.

Mrs. DAVIS. What would you anticipate then—where are the shortfalls going to be? Are there any, in terms of being able to do all the work that you really feel that you need to do to speed up this effort?

Mr. CAMPBELL. And, ma'am, we are going through that right now. We are analyzing that now to determine where all of the shortfalls are, what other parts of the electronic health records system we can postpone fixing until we fix these main issues. So we are still in the deliberations of that right now, ma'am.

Mrs. DAVIS. So there are some areas that won't be addressed?

Mr. CAMPBELL. The focus will be to fix the stability, the performance, and the usability of AHLTA.

Mrs. DAVIS. Is there a sense of how important this is?

Mr. CAMPBELL. Absolutely, ma'am. Absolutely. This is key. We understand—and, you know, we have had many different forums where we have talked to the users, whether it is through the Web halls, through town hall meetings. I have gone out to many facilities and directly talked with the providers there. We absolutely understand how important this is to fix this and make it right.

What we are doing with this not only is, though, important for just DOD, the stabilizing, making this work, building this new architecture we know is extremely important to support and enable what President Obama mentioned was the, you know, virtual electronic record with VA. And so this does support and enable that. So we understand how important this is, ma'am.

Mrs. DAVIS. For people who are watching and for families out there, I think we talk about the system itself, but how does this really affect the men and women who serve and their families? Why is it important to them?

Mr. CAMPBELL. From my perspective, ma'am, it is important for the users, the providers who use the system, who treat the patients, to have all of that information available wherever they are at and all of the information that they need to provide that care. It is absolutely important that they have that information and it is always available and the data is always available and the system is always available.

So we understand how important it is to the individuals. And not only that, from the longitudinal health record perspective, we understand how important it is to capture all of that information electronically so that, when a service member does retire or separate

and goes to the VA, they get all the benefits that they have earned and deserve.

Mrs. DAVIS. I wonder if the surgeon generals would like to respond. Is that a satisfying answer to you? And what information could you share with us, as well?

General SCHOOMAKER. Well, ma'am, I will take a stab.

I mean, I completely concur with what Mr. Campbell just talked about, as far as the central role of electronic health record. I mean, quite honestly, we are in an era——

Mrs. DAVIS. I think I am referring more to the issue we have around the budget and whether or not we are going to be able to do the work that is required and in a timely fashion.

General SCHOOMAKER. Well, I can't speak to that as much. I mean, I can tell you that, since the hearing earlier, the joint hearing that was held around the information system, certainly Health Affairs has redoubled their efforts to bring the services inside the building of a comprehensive strategy, rather than to piecemeal a plan that just Band-Aids over problems. I am getting feedback from our representatives on that group that we are doing some very serious, truly building the comprehensive strategy.

Mrs. DAVIS. That is good. Would you say that that wasn't the case before?

General SCHOOMAKER. No, ma'am, I wouldn't. That is what we said at the time.

Mrs. DAVIS. Okay. Thank you. Good to hear that.

Admiral.

Admiral ROBINSON. I am always careful when I get into the IT world because it is not something that I know a lot about from a technical point of view.

From a patient- and family-centered care point of view, the question you asked is, how is this important to the men and women, our beneficiaries? And the essence of care centers around the availability of relevant information that can be easily attainable at any time of the day and night in any place in the world.

So the impact of the casualty care system that we have encountered in Iraq, Afghanistan, with the CCATTS, with the Army, Navy, Air Force coming together, part of that has been based upon having good information. We have to have the same type of electronic medical records system in this country.

And I would also say, it is a patient issue, but it is also a provider issue. Our providers, in all services, want to have, must have, a capable system that is user-friendly and that will allow them to make the encounter with their patients the most meaningful and with the best quality of care. So this hits a number of issues, but, at the essence, it is the patient and the care issue and the quality issue that this becomes extraordinarily important.

There comes a point when trying to get it done isn't good enough; you have to get it done. And I am speaking now as a surgeon and as a physician, not as an administrator. You just have to—sometimes you have to get it done, and you have to get it done right.

I think that we are at the point now where Health Affairs—and Chuck and Mr. Campbell and all of the folks—are, in fact, doing the best that they can. But we really have to solve this because

this becomes a quality and a care issue that is not going to go away, and we will have to get this solved.

Mrs. DAVIS. Thank you.

General.

General ROUDEBUSH. Ma'am, I would certainly echo the thoughts provided. Information that is accurate, timely, and available is absolutely essential to the standard of care that we provide at home and deployed. It is absolutely critical to providing that level of care that is both expected and deserved. So I think everything that we need, in terms of delivering that care, needs to be present. Information is a central piece of that.

I would agree that the emphasis is appropriately provided. I think we are all in agreement that this is a central and critical issue. We are also in agreement that we have great work to do, much work to do, and that there is much yet to do.

I would offer one additional perspective. It is very important to the patient, no doubt about that. It is very important to the provider to be able to deliver that kind of care. But I would also suggest that it is an important retention issue for our providers, because it is a source of great frustration and very time-consuming as our medical professionals attempt to have balance in their lives, as well, between a satisfying and engaged practice of medicine at all locations—personal growth, professional growth, and time with their families. Having an information system that is an ally and an asset in delivering that care, finding that balance is important.

And AHLTA, frankly, has not been a positive factor in this discussion. It needs to be. And I believe the leadership has the appropriate focus. We will work to assure that we have the right plans and strategy in place. But we need to see that progress; this is a "show me" discussion.

Mrs. DAVIS. Uh-huh.

General SCHOOMAKER. Ma'am, at the risk of being gaveled down, I just have to pile on the one aspect. I mean, you held me to a discussion only about whether this can be done with the funding available, but I just have to add my thoughts to what my colleagues have said about how critical this is.

We tend to think of an electronic health record as an electronic way to manage our checkbook. But we have gone way beyond that. We are now in the realm of knowledge management, so that your checkbook is now embedded with an electronic universe where you are literally seeing the evolution of knowledge about how to use your money, how to invest it, where to place it, in real time.

And it is a very simple analogy, but one of the things that I would respond to you earlier in your question about how we are going to contain health care costs is by exploiting this knowledge of the network that we are developing.

I will give you two real quick examples. Earlier last year, the Food and Drug Administration (FDA) released a warning about a drug that was in common use. And they were getting anecdotal response that this was a potentially dangerous drug and it had side effects, but had no idea how big the denominator of use was. We were able to go in, through our electronic health record and the fact that we have catalogued all of those pharmaceutical uses and prescriptions, as well as any side effects and symptoms that are out

there, and almost immediately respond that, "Wait a minute, in our universe of users of this drug, we are not seeing problems, and it is probably far safer than you think it is."

H1N1 is another good example. We are able to monitor syndromes of illness, in real time, in people who show up at our hospitals and clinics, so that we can literally identify people who might be carriers of H1N1 and then surge to respond to that.

I mean, that is a knowledge network. And so it is organic to how we now give care. In fact, I monitor the use of AHLTA and the electronic health record not as an information measure of performance but as a clinical measure of performance. Does that make sense?

Mrs. DAVIS. Yeah. Absolutely.

And I think one of the issues that we have heard from men and women who are serving is even their location in the war theater and some of the problems that they are experiencing, how close they were to explosions that were occurring and whether or not those were deemed to be sufficient enough to have created a traumatic brain injury (TBI) or whatever that may be. And I think all of that kind of information is certainly critical.

Thank you. I appreciate that, and we may come back to it. I certainly want to let Mr. Wilson weigh in here.

Mr. WILSON. Thank you, Madam Chairwoman.

Thank you all for being here today.

Mr. Middleton, the National Defense Authorization Act for Fiscal Year 2008 required the Department of Defense to establish a joint pathology center (JPC). Can you tell us what the status is of the creation of that center?

Mr. MIDDLETON. Yes, sir, I can. We have an extensive working group that is looking at the mission that is described by the National Defense Authorization Act. As you know, that requires a certain management of the military referrals for pathology to oversee the tissue repository that remained from Armed Forces Institute of Pathology (AFIP). Will not be doing civilian consults, as you know, as well. So it is under way.

The placement of it in the organization is still being discussed. The Defense Health Board has looked at this, which is an independent advisory board that convenes at the behest of the Secretary of Defense, has looked at the JPC to figure out and make recommendations about the joint pathology center, its organizational location, et cetera.

So I think we are well on our way to implement what was described by law, for us build the JPC and, in concert with that, close down AFIP, which was described in the 2005 Base Realignment and Closure (BRAC).

Mr. WILSON. And there would be an opening date goal?

Mr. MIDDLETON. Yes, sir.

Mr. WILSON. And when would that be?

Mr. MIDDLETON. I will take that for the record and get back to you, sir.

[The information referred to can be found in the Appendix on page 113.]

Mr. WILSON. Good. Thank you very much.

And for our surgeon generals, I want to thank you all for your service. I am very, very grateful, as the son of a veteran; General Schoomaker and I were speaking a few minutes ago about my dad serving in the Army Air Corps. I am very grateful I served 31 years in the Army Guard and Reserves. I am particularly grateful that I have four sons currently serving in the military. And, with that background, I am so appreciative.

To me, I want more Americans to know and understand that American military medicine is the best ever. You are leading the world in prosthetics, promoting the ability for people to have replacements of arms, legs, hands. It is extraordinary what you are doing.

And I had the privilege of visiting with Major David Rozelle at Walter Reed, and I have visited Bethesda, I have visited Balad. I am grateful for the Wounded Warrior Programs that I have seen at Moncrief Army Hospital at Fort Jackson, at Beaufort Naval Hospital.

It is just so impressive what you are doing. And for the general population, it is going to be so helpful. And I want, particularly, persons who are in the military, their families, and then prospective members and their families to know that military medicine is the best in the world.

Additionally, with trauma care, particularly with improvised explosive devices, with brain injury, head injury. When I served in the State Senate 20 years ago, I worked on head injury issues, and now, thanks to military medicine, it is better than ever. I want to thank you.

And in regard to mental health issues, I really want family members to know that the military is uniquely situated to help people with mental health issues. General, you mentioned your battle buddy right back there. That is the way the military feels, and that is that each person who serves in the military, it is like a giant family. You care about each other. And you also have a finite population; you have a somewhat controlled population.

And so people should know that the ability for mental health care, I think, is better in the military than any other segment of our population. And I am the former president of the Mental Health Association. I have worked on this issue for 40 years. And so I know the extraordinary abilities and efforts that are being made for our personnel.

A concern I do have is screening prior to recruiting persons. And then, we know the stresses of normal life—and that is, it can be financial, it can be the breakup of a family, it can be a divorce, child custody, it can be drugs and alcohol. But what is being done for prescreening, and then what is being done for our service members who have not just post-traumatic stress disorder but the normal stresses that Americans and world society face?

General ROUDEBUSH. Sir, we, the military, live in the broader population of the United States. As men and women raise their right hands, swear to support and defend, we are drawing from communities across the Nation. We have individuals who come to us in good health. They are appropriately screened in terms of their physical and mental health history. But each one arrives as an individual, with their own set of coping skills, their own history,

if you will. And, as a military, our job is to assure that they are provided the support that they need in order to both serve and operate in some very demanding environments, but to also have the help and support that they might require at some point, if, in fact, circumstances dictate.

I believe our screening is appropriate. I believe our screening is bringing us individuals of good physical and mental ability. I think it is incumbent on us that we continue to have very strong continuing screening and surveillance to assess and detect circumstance as they occur during an individual's period of service and to have the capabilities to intervene appropriately as we move through.

So I believe that our pre-screening and our pre-assessment brings us good individuals willing and able to do our Nation's work. And our job is to ensure that we continue to support them in that endeavor and to have the right capabilities to assist them if such assistance should be required.

Ms. SHEA-PORTER. The first one has to do with the report that the defense contractors have been receiving medical care and not reimbursing the Federal Government. It has been costing taxpayers about $1 million a month for that. And indeed, when the Inspector General (IG) took a look at the report, you didn't even have any standards set up or any way for military medical personnel to keep track of how many people they were treating. And so my question to you is, why did that happen? Why did the taxpayers have to pay, in addition to all of the other money they pay contractors, a million dollars a month for the medical care? And what are you doing about it, please.

Mr. MIDDLETON. Thank you.

The issue of how that happened, I think, had to do with exigencies of a war situation and moving many contractors in where we hadn't seen that before; providing emergency care for those that are injured in the line of their duties during the period of their time; and our lack of those kinds of business operations systems in the deployed setting.

In our civilian setting, we have collections, and we have registration. We have scheduling. We have all of the revenue cycle issues that you would see in a normal health care setting. We didn't have all of those initiatives, those things, in a deployed setting.

Ms. SHEA-PORTER. Well, can I interrupt right now and ask, why not? Because when they drew up the contracts, they are pretty detailed contracts for pretty much everything, and the contractors manage to get in coverage for many, many things. And so if we were putting that much attention to contracts in general and knowing that they would be requiring medical care, I don't understand the answer, if I understood you correctly, that we were too busy, too rushed, too many people coming in. Because they managed to take care of their part of the business contract, and I think that we should have taken care of the taxpayers' part of the business contract.

Mr. MIDDLETON. I would certainly agree with you, ma'am. And as a result of that Government Accountability Office (GAO) report, we have taken a look, with the Services, to take a look at what we

can do in that deployed setting in order to capture that information that we need in order to make those claims for health care dollars.

So we didn't ignore that GAO report. We are certainly going to take action on that GAO report. In fact, there is a working group that I am familiar with that is actually looking at that right now in fact to figure out how we can go about doing that process.

Ms. SHEA-PORTER. Will we be reimbursed?

Mr. MIDDLETON. I don't know the answer to that question, ma'am. I don't know the contractual arrangements of that for that particular answer, but I will certainly take that back as part of the work group to find out.

[The information referred to can be found in the Appendix on page 113.]

Ms. SHEA-PORTER. Thank you.

And then the second part is I wanted to ask you a question about dwell time. I was an original cosponsor of requiring more dwell time for our troops. And as a former military spouse, I think this is absolutely essential for these family members to have this. My husband never went into combat, but it was during the Vietnam era, and we certainly saw a lot of the fallout, if you will.

And so my question is, how much time do you think our military men and women need as a minimum for dwell time? And are there any plans to create more dwell time for them?

Mr. MIDDLETON. Ma'am, I don't think that is a question that I would have the answer to personally. That is not something that is in the cognizance that I have and the responsibilities that I have been given. Not to defer to the surgeons, but they may have better insight on that from the service perspective.

Ms. SHEA-PORTER. I am happy to do that. I was going to work my way right now. Thank you.

General SCHOOMAKER. Well, ma'am, the Army does focus on dwell time. It has been a major frustration to Army leadership and soldiers and families that the demand on soldiers, prior to the growth of the Army, has really demanded deployments with sometimes dwell times, that is time back at station with family, that did not equal to or exceed the amount of time spent deployed. That was especially true during the surge when we went to 15-month deployments.

I was asked by another committee last year about what I felt on the medical side and, especially from the standpoint of behavioral health, what the optimal deployment length was, and at that time, based upon the results of the—and this is a medical response, not an operational response. I mean, the operational—the length of a deployment is much driven by and dictated by the operational requirement.

Below a certain point in the Army, for troops on the ground, one could make the argument that it is dangerous; that one needs to have sufficient time to have continuity of command and to learn and to operate effectively and in theater. But based upon the results of the Mental Health Advisory Teams that we have put into Iraq and Afghanistan now, the sixth one is on the ground now in Afghanistan and has just finished in Iraq, I responded by saying that I think there are three factors.

One is the length of the deployment. We know that after nine months or so, deployment length for soldiers is quite onerous. Above 12 months and into 15 months, we saw very clearly that problems began to almost grow exponentially.

I thought the second factor is dwell time. And at that time, I gave the kind of seat-of-the-pants answer that the best advice I could get from those who have experienced that is 18 months minimum.

I think the current Mental Health Advisory Team, which is just coming back from Iraq and Afghanistan, will give us some of our best data. And I have not seen that data yet, and I am anticipating it coming out, and it will help give us an idea of optimal dwell time is.

And then the last thing I said was the number of deployments, frequency of deployments.

So I think it is a function of length of deployments, dwell time between deployments, and the frequency. All three are determinants. The Army's aspiration is to have soldiers dwell, you know, at minimum 24 months between deployments, so you are one out and two back. And for the Reserves, to be on a more generous cycle of four to five years of dwell between deployments.

Does that answer your question?

Ms. SHEA-PORTER. Thank you. Yes, and I know you have had concerns about this issue, and I appreciate it.

Admiral ROBINSON. I think that General Schoomaker summed up my view on this very much in his three answers, and I think that the dwell time is absolutely incredible.

I think that the thought on dwell time has been what my mental health experts have said is a way to not only reset the individual but also reset the family. So it is not just a soldier, sailor, airman, or an active person's reset; it is also a family's reset. And it has to occur over a length of time where the reset can actually occur. That was my only addition.

Ms. SHEA-PORTER. Thank you.

General ROUDEBUSH. Yes, ma'am.

And from an Air Force perspective, of course, this is a line discussion which by extension we certainly reflect from a medical perspective our support of the line activities.

General Schwartz has made it very clear that the Air Force is all in, so the driver is the demand signal: What is required to support the mission, wherever we find it in the world?

Now, having said that, we also understand that for a repetitive aerobic deployment cycle, that dwell time is critically important. So as we look at the operational requirements, which at times may require an extended deployment to work effectively in some of the environments, building relationships, working extended programs with individuals where that relationship is paramount, can drive some of those operational requirements, and that exists medically as well. But our line leadership has been very forward leaning about matching the pipeline to the demand signal.

And if we need to make a difference in terms of building more of an asset, could be low-density, high-demand asset, in order to increase the opportunity for individuals to deploy, but then come back home, retrain, reblue, reintegrate with family before the next

deployment experience, that is a key parameter of what we do. Our banding efforts in doing that I think have gone a long way.

But I share my colleagues' concerns that, that dwell time is critically important for an All-Volunteer Force, the majority of whom have families and want to continue to serve and do so effectively.

Ms. SHEA-PORTER. Thank you very much.

Mrs. DAVIS. Thank you. And I am going to follow up, and I understand you have another question, and we will come back in a second.

As we have spoken about this, we know how important it is. And getting back perhaps even to the IT system, how much tracking is done of the number of deployments that people have had and that our service members have had and their dwell times? And how is that communicated to the military leadership, the commander on base and some of the subordinates there? Because I am just wondering whether there is an appreciation of what that service member has gone through and how that factors into any other relationships or any other concerns that are made. Is that information readily available, and how is it used?

General ROUDEBUSH. Ma'am, I can speak to that from the Air Force.

Our Air Force Personnel Center and our Air Expeditionary Center, which oversees both deployment and operational engagement, follow that very closely. Particularly if in fact an individual may deploy, come back to home station, and then be transferred to another home station; do they enter into a new environment where that deployment is not recognized? No. That is tracked through.

Now, from a medical perspective, we also track closely on cohorts of individuals perhaps at increased risk, our explosive ordnance personnel, our terminal attack controlling personnel, among others, security forces, because their exposure and their experience puts them at higher risk of post-traumatic stress, TBI, those sorts of outcomes. So we track them as well to assure that we are monitoring and supporting them over an extended period of time and not simply during a singular deployment.

Admiral ROBINSON. From the Navy's perspective, Navy Personnel Command has this wrapped up very tightly. It has been an interesting evolution because, in this particular conflict, or conflicts, or wars, there have been individual augmentees. So there has been—and on the Navy side, there are 14,000 individuals, and there are comparable numbers on the Air Force. The Army and Marine Corps side have the same, but they also have units. So for the services that have had the individual augmentees, it has become a challenge at the very beginning to make sure that we did keep up with them and make sure that we did know who was coming in and out of certain theaters and where they had been. And when they got transferred—and this is very important—or even when they came back to their home station, often there would be people there or whole groups of folks that wouldn't understand where that individual had been.

So this has been taken up from Chief of Naval Operations (CNO) and Chief of Naval Personnel, and these are tracked. We are right on top of where the individuals are, where they have been. We absolutely wrap them up and keep a close contact with who is gone.

And in some instances, we even, in some types of positions and jobs, we even have policies in place that you don't repeat a deployment or you don't repeat the same deployment for that individual. You have to get new people in. It depends on what the situation is. But they are very well tracked, and the Navy Personnel (PERS) and Chief of Naval Personnel has this information. It is readily available to all of us who need it.

General SCHOOMAKER. And, ma'am, for the Army it is exactly the same thing. The personnel community tracks this down to the day, and it is reported to the very highest level. I know that all senior leaders of the Army, the Chief and Secretary and Vice Chief level, track this extraordinarily closely.

Rather than just repeat everything that my colleagues have said, because it is identical in the Army, let me just comment about when in dwell. Another thing that has become very evident to us is that when back home, if you return from combat and then almost immediately go out to train, it is equivalent to being deployed again, although not to a combat zone. So there is a lot of focus being placed upon reintegration and reset.

In fact, I think the chief's ambition is that we have an almost inviable six-month period once a soldier returns where they can reintegrate and reestablish with family, that we can do the necessary screening for the emerging symptoms that they may experience from post-traumatic stress and the like, and that we can institute that human dimension reset that we have talked about.

And I think what we are learning, and your questions are very well poised to address, is what is the human dimension inside of these almost institutional and industrial processes of iteratively preparing a soldier to go to war, deploying that soldier, and then bringing them back and reset. You can reset the equipment. You can reset their tactics, techniques and procedures, but the human dimension sometimes is on a different time scale.

Mrs. DAVIS. I think one of the concerns that I have heard is, it partly relates to readiness, but the fact that a smaller percentage of men and women are able to actually return to theater after multiple deployments, or that we are relying I think on a smaller proportion of people who are serving. Is that a correct assessment?

General SCHOOMAKER. Ma'am, I don't think that is an entirely accurate depiction of that.

I mean, some of the most frequently deploying units are, for example, Special Operations units, which have deployed maybe 10 times or more. And deployment experience alone—I mean, in suicide, for example, suicide is not necessarily predicted by more frequent deployments. In fact, a third of Army suicides are in soldiers who have not deployed at all. And as one deploys more, what we are finding is that the suicide rate drops.

Now, that might be a reflection of the fact that once—that if you have difficulty with deployment, that you are unlikely to remain longer after that first deployment. And so that we enrich for a population of families and soldiers who can endure multiple deployments.

Mrs. DAVIS. Are we pulling people from theater when we do see after several deployments that in fact this is not something that is going to move forward with a good outcome for them? I mean, is

that something—do we have numbers that are being assessed once returning to theater that it is not a good idea for them to be there?

General SCHOOMAKER. Well, we certainly in theater very aggressively address in-theater behavioral and mental health. We have, again, one of the major efforts of Mental Health Advisory Teams that have been going in for the last six years was to exactly assess that: What was the level of mental health support? And was it available to a very disbursed force, both in Afghanistan and Iraq? As you saw the other day in the tragedy, I mean, this was a Combat Stress Control Team that was out there with soldiers and Marines and others and sailors that was conducting health care on the battlefield, literally.

Mrs. DAVIS. Mr. Wilson.

Mr. WILSON. Another perspective on deployment, I know our office has helped expedite in my local community with the National Guard one of the most prominent certified public accountants (CPAs) in our community who wanted to be transferred from one National Guard unit to the other to be deployed.

And then, Admiral, I am very grateful that, at Fort Jackson, South Carolina, the augmentees you mentioned, the sailors, the naval personnel are being trained there to be sand sailors. And it has been very inspiring to me to go out and visit these sand sailors as they are on their way to Iraq and Afghanistan. And when I visit with them in Kabul or Baghdad, they are so grateful for their opportunity to serve.

And I am also very pleased, I can now also mention my Air Force connection, I am very proud to have a nephew who has recently returned to theater, and it is his second deployment. And these are volunteers. They want to serve. They want to protect our country. So thank you very much.

General ROUDEBUSH. Madam Chairman, if I might. If I could put one other perspective on your scope.

We have significant numbers of people who do not in the traditional sense deploy. Our airlifters, who are moving people and things critically important to our effort as well as providing air medical evacuation around the world, do not deploy. But they are gone from home for extended periods of time, launching every 90 seconds around the clock, 24/7, 365. They, too, need to be very carefully supported and attended to because of their critical piece of the mission.

We have unmanned aerial vehicle (UAV) operators at Creech in Nevada who don't deploy but have not had leave, have not had time away, have been basically focused on providing that unblinking eye above our Marines and soldiers in important parts of the world who have a particular kind of stress that applies to their life and their world as well.

So it is broad spectrum of people who serve who may not traditionally deploy but are pulling their boots on every day to serve combatant commanders and our Nation in a variety of ways that we can't lose sight of either.

Mrs. DAVIS. Thank you.

Just one quick follow-up, and then I want to go to Ms. Shea-Porter.

I know we have done a far better job in trying to educate our military leadership in the field at all levels in which they are accountable for their troops to be more aware, to be able to help share information, to create an atmosphere where people are comfortable. But I am wondering if there are some ways in which we can do an even better job there in trying to help them in how they help their troops deal with the death of comrades, best practices or trying to at least—everyone is not going to respond to the same way to these tragedies, but perhaps helping them understand better the way that the next few days weigh out really for them makes a difference in the way people are going to be able to handle.

How much time are we really spending in trying to help educate, to consult, to counsel them in that way? It is a busy theater. There is not a lot of time to do that. And I am just wondering how critical it is and whether we just need to think more about how we do that.

General SCHOOMAKER. I will tell you about three initiatives the Army has undertaken in the very least. One was about a year ago, the senior leadership of the Army initiated really an unprecedented chain teaching effort, right from the very top of the Army, the Chief of Staff and the Secretary right down to the last soldier, to impress upon them the importance of reducing stigma and recognizing that the human cost of deployment and exposure to combat for all humans was experiencing some degree of behavioral and health challenge and emotional challenge.

We are working in the comprehensive soldier fitness arena to make that experience not a lifelong disability, but actually to exploit post-traumatic growth, because as many more people return from this experience having been enriched in the sense of having seen a meaningful aspect of their life in uniform that they didn't experience before. That goes back for many wars and many militaries. So that was the first.

The second is a more recent effort to intervene and prevent suicide, in which we have had a mandatory standdown as an Army, with small unit teaching by facilitators using, in a very good interactive video, called "Beyond the Front," in which you role play several different roles. One is a young soldier who is deployed and is experiencing many challenges to include the breakup of a relationship back home, a loss of a buddy in combat, financial issues, and the like. And you work through this interactive video.

The other is, back in home station, a senior NCO who has got a fellow NCO who is literally falling apart in front of his eyes with family problems, alcohol use, and the like. And you are asked in this interactive fashion to make decisions what you are going to do and then go down those branches and sequels, and then go back and restudy it.

Those are just several very important efforts that we have undertaken to educate and train.

The last is the Battlemind Training. The Army has developed a series of sort of branded tools called Battlemind Training that prepares soldiers and families to be deployed, and then are used even in redeployment that sensitize the entire force to, again, the emergence of symptoms and problems that are associated with service and deployment. And these have been integrated into all enlisted and officer training throughout the life cycle of every soldier so that

they are exposed, again, to your point being made, that, are we making efforts to educate and train? Absolutely.

Mrs. DAVIS. Thank you, General. And I guess the next question is, how are we evaluating that? And are we going to be able to—I am interested and I don't know.

General SCHOOMAKER. Battlemind has actually been validated. And the Mental Health Advisory Teams have seen in subsequent years that stigma, for example, has been reduced when they go out and survey the force.

Mrs. DAVIS. Thank you.

Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you.

I really appreciate your sensitivity, all of you, to the needs of the military. I want to talk about their families. And I know you share those concerns. But I had a chance to mention to Secretary Gates the other day to please consider this, and I wanted to bring it up to you also.

I know and I have heard some stories about children whose parents are both deployed in theater. And I worry about the impact on the children. I do know that the mission has to come first, and that if you need personnel, you need personnel. However, I would like to ask how much consideration you give to those couples who have children who are seeing repeated deployments.

And the stress on the children is pretty awful and the stories that the parents tell are heartbreaking. And so, can you give me an idea of how many, first of all, parents are there who are both deployed in theater, so that I can see the extent of the problem? And what is being done for the children and the families to try to minimize the impact? Are you trying to rotate so they are not both in theater, et cetera?

General ROUDEBUSH. Ma'am, I can speak from the Air Force perspective. That circumstance is, fortunately, relatively rare. Our Air Force Personnel Center and the Air Expeditionary Forces (AEF) center do work to avoid simultaneous deployments.

But I would also add that the family has the opportunity to weigh in on that both in terms of providing plans that are appropriate for their family to assure that the youngster, if in fact the circumstances might dictate a simultaneous deployment, to place those children in the most appropriate place, whether it is with a close relative, whoever might be the most appropriate.

Ms. SHEA-PORTER. The problem with that is that with repeated deployments it is more and more difficult for those. And plans fall apart. People who have the best intentions suddenly have circumstances change. And so I appreciate the fact that there are plans, but we both know that life gets in the way of plans.

General ROUDEBUSH. I don't diminish the importance of that at all and understand that certainly can occur. But to the extent fully possible, our Personnel Center, our AEF center, including the individual's commander, those individuals' commanders have a voice in that decision. So we do find that to be relatively rare in the Air Force.

General SCHOOMAKER. Ma'am, for the Army, I would have to take it for the record as to what the actual numbers of both parents being deployed are, and we will get that back to you.

[The information referred to can be found in the Appendix beginning on page 113.]

General SCHOOMAKER. But I think we have a number of single-parent families that for whom the parent is deployed, and so some of the concerns I think that you have expressed with both parents being gone extends to those families as well.

I can tell you that there are several initiatives ongoing within the Army and the military community in general about this. Our current Secretary of the VA, Secretary Shinseki's wife, Patty Shinseki, is very active in the Military Child Education Coalition, which is doing outreach into the education community to find support for children and to be sensitive to the needs of military children, especially those for deployed parents.

There are pilots ongoing in the Pacific Northwest around Fort Lewis, Washington, and Tripler Army Medical Center in Hawaii for that right now, and they are undertaking a number of studies and outreach programs and educational for that.

Our chaplains are playing a very role, too, with outreach to the ministerial community to extend services and be sensitive to it and be monitoring and helping our children in those kinds of situations. So I think there is great sensitivity about what you are addressing, ma'am, and we are looking very actively at that.

Ms. SHEA-PORTER. Is there any particular place they can go when a family feels strained to the breaking point? And what is the procedure? How would a mother, for example, say, I thought I had a good plan, but then my husband got deployed, and we left the kids with grandma, but she got sick, and then we passed the children off to so and so? Do you have some kind of caseworker or person assigned to follow, and I am sure that the number of families aren't that great, but to work particularly with those families? Or do you think that would be helpful?

General SCHOOMAKER. Ma'am, that happens. All of those assets are available, and starting with the chain of command for the soldier. The NCO and officer chain of command is immediately engaged in situations like that, because the health and well-being of that family is extraordinarily important to that command.

Ms. SHEA-PORTER. But do they have criteria or directions, say, if they do take it to the chain of command, and the chain of command may or may not consider that as critical as the family member does, what is the next step?

General SCHOOMAKER. The chaplains getting involved. The health care community gets involved in a sense validating or documenting the state of the family. And commanders are very sensitive to this, in my experience, and will bring a deployed soldier home or divert them from an assignment that they may be undergoing until that family situation stabilizes.

Ms. SHEA-PORTER. I just want to make it very clear for the families that they know where to go and what path to take.

So thank you.

Mrs. DAVIS. Thank you, Ms. Shea-Porter.

And I know that some of those questions come out of the trip that we took to Afghanistan over Mother's Day and spoke to a number of, happened to be, mothers who were experiencing some of these difficulties with double-deployed households. And it wasn't

easy, and we tried to support them and try and lead them to some of the services that might be available to them. It is tough.

I want to thank you all very much for being here. I know we have some deadlines that we have to meet today. And we appreciate it.

One of the issues that you brought up earlier and we didn't address in any great detail was really developing the men and women in the health care professions that would be needed over the next number of years. And we also didn't talk about the private sector and what we can do to encourage more professionals to come in and be supportive, either through other contracts or what communities services, and so that would be an issue that we will ask you about in written questions and look forward to some responses in that as well.

Again, I want to thank you very much.

Thank you, Mr. Wilson and Ms. Shea-Porter.

And the meeting is adjourned. Thank you.

[Whereupon, at 10:38 a.m., the subcommittee was adjourned.]

A P P E N D I X

MAY 15, 2009

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MAY 15, 2009

Opening Statement of Chairwoman Susan Davis
Hearing on Fiscal Year 2010 National Defense Authorization Budget Request on Defense Health Program
May 15, 2009

Today, the Military Personnel Subcommittee will hold a hearing on the Department of Defense's Fiscal Year 2010 budget for the Defense Health Program.

For the first time in three years, the Department of Defense has not proposed massive TRICARE fee increases as part of their budget request. The increases proposed in previous years would have provided large savings for the department, but most of the savings would have been the result of raising fees so high that large numbers of beneficiaries would choose to leave the system. We are encouraged that the department has not chosen to pursue that course of action this year.

The Secretary of Defense has said that his intent was to fully fund military health care in the fiscal year 2010 budget, and then engage Congress in a dialogue about what comes next. We will obviously have to wait to start that coversation until the President's appointees are in place, but we look forward to the discussion this committee has been trying have with the department for years. Our beneficiaries deserve no less.

We must now closely examine the budget proposal to see if it is indeed "fully funded". I should mention that we have only had the budget justification materials for about 36 hours, and are still awaiting answers from the department on various issues. It would be helpful if our witnesses could offer any insights they may possess on how certain amounts were chosen and various decisions made.

During our annual reviews of the Defense Health Program budget, we always ask questions about how the proposed budget will support our deployed service members and their families. In light of recent events, we will undoubtedly focus additional attention on how this proposed budget will improve mental health services, as well as any unfunded mental health requirements the services may have.

For our witness panel, we have the Acting Principal Deputy Assistant Secretary Defense for Health Affairs, Mr. Allen Middleton, representing the Office of the Secretary of Defense. Until recently, Mr. Middleton was the Acting Deputy Assistant Secretary of Defense for Health Budget and Financial Planning, so he will be able to answer our budget questions in great detail.

We also have all of the service surgeons general, Lieutenant General James Roudebush from the Air Force, Vice Admiral Adam Robinson from the Navy, and Lieutenant General Eric Schoomaker from the Army. General Roudebush, I understand that you will be retiring in August, and that this may be your last appearance before this subcommittee. I would like to thanks you for your service, for the quiet determination with which you have led the Air Force Medical Service, and the unwavering commitment you have displayed for our men and women in uniform. You will be missed, and we wish you well in your future endeavors.

Opening Statement of Ranking Member Joe Wilson
Hearing on Fiscal Year 2010 National Defense Authorization Budget Request on Defense Health Program
May 15, 2009

"Thank you Chairwoman Davis. Today the Subcommittee meets to hear testimony on the Defense Health Program for Fiscal Year 2010. Although we routinely have an annual hearing on the DHP, I want to emphasize that there is nothing routine about the military health system and the extraordinary care it provides to our service members and their families.

"The subcommittee remains committed to ensuring that the remarkable men and women who are entrusted with the lives of our troops have the resources to continue their work for future generations of our most deserving military beneficiaries. I would like to express my deep appreciation to all of the military health system leadership and personnel who are responsible for delivering the highest quality healthcare during these most challenging times.

"To begin, I want to commend the Department of Defense for sending us, for the first time in four years, a fully funded budget for the Defense Health Program. I applaud Secretary Gates for hearing what Congress and our military beneficiaries have said repeatedly; increasing TRICARE fees is not the solution for containing the rising cost of military health care.

"With that, I am anxious to hear from our witnesses today how the Department plans to develop a comprehensive approach to providing world class health care to our beneficiaries while at the same time controlling costs. I look forward to working with the leadership of the military health system toward that end. I would also like your commitment that all the stakeholders in military health care will be involved in the process.

"I am interested in hearing from the witnesses how the DHP supports the critical mental health services needed by our service members and their families, particularly the National Guard and reserve members who rely primarily on TRICARE Standard.

"I would like to hear from our military Surgeons General whether the DHP will fully support their responsibility to maintain medical readiness, provide healthcare to eligible beneficiaries, provide battlefield medicine to our brave men and women in Iraq and Afghanistan and care for those brave men and women through the long recovery process when they become injured and wounded.

"With that, I would like to welcome our witnesses and thank them for participating in the hearing today. I look forward to your testimony."

STATEMENT BY

ALLEN MIDDLETON

ACTING PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE
FOR HEALTH AFFAIRS

REGARDING

THE MILITARY HEALTH SYSTEM: BUDGET OVERVIEW

BEFORE THE

HOUSE COMMITTEE ON ARMED SERVICES

SUBCOMMITTEE ON MILITARY PERSONNEL

MAY 15, 2009

FOR OFFICIAL USE ONLY
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Madame Chairwoman, Members of the Committee, thank you for the opportunity to discuss the priorities of the Military Health System (MHS) and its budget for fiscal year 2010. We are pleased to be here.

The men and women of America's Armed Forces are our country's greatest strategic asset. Apart from defending the Nation, the Department has no higher priority than to provide the highest quality care and support to our forces and their families.

As Secretary Gates has said, "At the heart of the all-volunteer force is a contract between the United States of America and the men and women who serve ... A contract that is ... legal, social, and sacred.

"When young Americans step forward of their own free will to serve," he said, "they do so with the expectation that they, and their families, will be properly taken care of ..." [1]

MHS Mission and Strategic Plan

Madame Chairwoman, that commitment, which dates back to the Civil War, is engraved in granite on the Lincoln Memorial, along with Lincoln's pledge to care for those who "have borne the battle." We take it seriously. And it encompasses not only the wounded, but all who serve.

Indeed, the Military Health System (MHS) has one overarching mission: to provide optimal health services in support of our Nation's military mission – any time, anywhere.

Today, the MHS serves 9.4 million beneficiaries, including retired military personnel and their families.

In addition to force health protection and family support, the MHS provides humanitarian assistance at home and around the world, and supports world class medical education, training and research.

Our strategic plan, developed in concert with the Surgeons General, and the Joint Staff – supports all of these mission components. It also recognizes the outcomes the American people expect from their investment in military medicine.

In addition to a fit, healthy and protected force, our goals include the lowest possible rate of death, injury and disease during military operations; superior follow-up care that includes transition to the Department of Veterans Affairs (VA); healthy and resilient

[1] From speech delivered by Secretary Gates to the Wounded Warriors Family Summit, *Monday, October 20, 2008, Washington, D.C.*

individuals, families and communities; and the highest quality care at the lowest possible cost to the taxpayer.

We appreciate the support the Congress, and especially this Committee, has provided to help us provide the very best health care for our forces and their families, and in particular for the wounded ill and injured. While there is always much more that must be done, I believe we have made significant progress toward each of our goals, and I would like to tell you where we are, and what we have accomplished.

A Fit, Healthy and Protected Force

Madame Chairwoman, contrary to common assumption, the single largest contributor to loss of forces is not combat, but disease and non-battle injuries. To keep our forces fit and ready, health assessments are performed on accession, annually, and each Service member prior to deployment, following deployment, and again 90 to 180 days after a Service member has returned to home station.

These health assessments not only provide a comprehensive picture of personal health, but highlight areas of concern, provide an opportunity for additional education, evaluation, or treatment, if necessary; and give commanders a view of force readiness down to the individual level.

Vaccinations are another way to protect force health, particularly against serious illness and disease. Smallpox and anthrax, for example, continue to be viewed as real threats, as well as potential bioterrorism weapons that could be used against our forces. After the Food and Drug Administration (FDA) confirmed the Anthrax Vaccine Absorbed (ABA) safe and effective for individuals at high risk, the Department restarted the anthrax vaccination program. We also implemented FDA-approved changes for a reduced number of doses, which will lower both the number of needed inoculations and the cost.

To date, DoD vaccines have protected almost 2.2 million Service members against anthrax, and more than 1.75 million against the smallpox virus. These vaccination programs have an unparalleled safety record, and are setting the standard for the civilian sector.

The Department continues to lead the world in disease surveillance, education and rapid eradication of global epidemics including influenza. Indeed, DoD influenza surveillance assets offer a global perspective of emerging infectious diseases that not only impact the Department but overall national security – and national health.

In the recent H1N1 outbreak, for example, Defense surveillance assets were responsible for identifying the first two cases in California and Texas, and we continue to be actively engaged with other federal agencies to ensure that the Department's response is

consistent with national efforts and guidelines. In addition, the Department has established stockpiles of medications and other materials to ensure its ability to meet mission requirements anywhere, any time.

As a result of these and other measures, the Disease, Non Battle Injury (DNBI) rates for Operation Enduring Freedom and Operation Iraqi Freedom are the lowest ever reported – 5 percent and 4 percent respectively for Operation Enduring Freedom and Operation Iraqi Freedom, as compared with 5.6 percent in Operation Desert Shield/Desert Storm, 7.1 percent in Operation Joint Endeavor (Bosnia), and 8.1 percent in Operation Joint Guardian (Kosovo).

Thanks to the dedication of the men and women who rapidly reach, evacuate, and treat the wounded, the Death to Wounded Ratio has also dropped. In the past, battlefield medicine was a tricky business. Reaching the wounded warfighter in time to impact his chances of recovery was uncertain at best, and most did not survive the process. Today, every US soldier, sailor, airman and Marine – regardless of location– can rely on state-of-the-art treatment and equipment within the first hour of injury. As a result, the battlefield survival rate now stands at 97 percent, as compared with 75 percent in World War II and 81 percent in Vietnam.

Using aeromedical intensive care units (Critical Care Air Transport Teams) and the latest technology, US medics have significantly reduced the amount of time it takes to evacuate the wounded, moving personnel from forward deployed surgical units on the battlefield to the highest quality care in the United States in as little as 48 hours.

With regard to environmental health protection, Service Occupational and Environmental Health (OEH) specialists routinely monitor air, soil, water and other aspects of the environment in theater to detect and prevent hazardous exposures before they occur. To date, more than 11,000 environmental samples from Iraq and Afghanistan have been collected and analyzed, and new samples are constantly reassessed. Findings to date indicate a low risk to our forces for any long-term health effects from environmental exposures.

In addition, through a multinational agreement (Chemical Biological Radiological Memorandum of Understanding) with Australia, Canada, and the United Kingdom, the MHS is now also sharing this data with our allies to increase their situational awareness of OEH threats in deployed locations, reduce redundancy and duplication of effort, and strengthen their ability to protect deployed forces.

Superior Follow-up Care, including Wounded Warrior and Transitional Care

In addition to prevention, follow-up care is also paramount, particularly for Service members with psychological health needs or traumatic brain injuries (TBI).

The Department is committed to ensuring that every wounded or injured Service member, especially those with psychological health or traumatic brain injuries, receives consistently excellent care across the entire continuum of care – from prevention, protection and diagnosis to treatment, recovery and transition from the Department of Defense to the Department of Veterans Affairs.

In 2007, the Department embarked upon a comprehensive plan to transform our system of care for psychological health and TBI. The plan was based on seven strategic goals:

- Building a strong culture of health leadership and advocacy;
- Improving the quality and consistency of care, across the country and around the world;
- Creating easy and timely access to care, regardless of patient location;
- Strengthening individual and family health, wellness, and resilience;
- Ensuring early identification and intervention for individual conditions and concerns;
- Eliminating gaps in care for patients in transition; and
- Building a network in which to leverage and/or direct medical and cross-functional research, including new and innovative treatments, technologies, and alternative medicine techniques.

Throughout 2008, we made significant progress toward achieving each of them.

We established the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to lead the effort to develop excellence in prevention, diagnosis, practice standards, training, outreach, and direct care for those with psychological health and TBI conditions, and to provide the nexus for research planning and monitoring.

Since its inception, the DCoE has focused its efforts on the development and continuous improvement of a patient-centered network dedicated to all issues related to psychological health and TBI. Approximately $58.2 million was obligated in FY 2008 to establish the DCoE and supporting networks.

To improve the quality and consistency of mental health care, DoD, in full partnership with VA, continue to develop and update clinical standards and guidelines, share lessons learned and best practices, and establish evidence-based care as the enterprise standard for acute stress disorder, posttraumatic stress disorder (PTSD), depression, and substance use disorders. Over the past year, the Clinical Practice Guideline for depression has been revised, and the existing "Guideline" on PTSD is being updated.

A new evaluation tool, the Military Acute Concussion Evaluation tool, was introduced in USCENTCOM to assess the likelihood of mild TBI. Clinical guidelines for its use in operational settings were also published. TBI certification programs in military medical

treatment facilities were established and standardized protocols for determining if a member should return to full duty or to the United States for further treatment were implemented.

The Department also joined with the VA to implement a standardized training curriculum on evidence-based psychotherapy for PTSD, and trained more than 2,700 providers in evidenced-based treatments for PTSD and TBI.

To recognize the challenging diagnoses and unique requirements that can accompany psychological health and TBI wounds, the DCoE worked with the Intrepid Fallen Heroes Foundation to support the design of a new facility, the National Intrepid Center of Excellence (NICoE).

The new Center will provide an interdisciplinary team of clinicians and scientists dedicated to a holistic evaluation and treatment approach for Service members with mental health and TBI conditions, and provide advanced diagnostics and comprehensive treatment planning for those whose mental health conditions or traumatic brain injuries are not responding to traditional methods. When the new Center is complete, we expect that there will be no finer care available in the country, or perhaps the world, for wounded warriors with these conditions.

In a similar manner, the DCoE, the National Institutes of Health (NIH) Office of Research on Women's Health (ORWH), and VA, are working to identify and explore the existing science on trauma spectrum disorders (such as PTSD and TBI) related to military deployment, and the DoD and VA are working together to foster partnerships between suicide prevention experts in government, medicine, and communities.

To improve access to mental health care, regardless of location, we provided funds to the Military Departments to hire additional mental health and other specialty providers, and implemented a policy that requires first appointment access within seven days for mental health concerns.

Approximately $32.6 million was obligated to improve the quality and consistency of mental health and TBI care in FY 2008.

Under DCoE, the Department also initiated a telehealth network for clinical care, medication monitoring, support and follow-up for individuals with TBI or stable mental health conditions, including a number of Web-based applications that deliver real-time mental health services, and telehealth-delivered services – especially important to those in rural and underserved locations – to improve and augment access for those concerned about stigma. A new anti-stigma, pro-resilience campaign entitled "Real Warriors" will be launched nationwide this month. Approximately, $227 million was obligated to improve access to mental health and TBI care in FY 2008.

The Department is working with its federal and private sector partners to eliminate gaps in care as patients transition through the various health systems, or to different duty locations.

For example, we recently established an assisted living pilot program in Johnstown, Pennsylvania to improve functionality and independent living after TBI, and to provide valuable insight for replication in other areas where appropriate. We helped establish the Federal Care Coordination program and stood up a TBI care coordination system to integrate Federal, State and local resources.

A new program, *In Transition*, will be launched early June to maintain the continuity of mental health care for Service members transitioning between military treatment facilities and affiliated healthcare systems such as TRICARE and the VA.

The *In Transition* program proactively facilitates a Service member's transfer from one healthcare system to another, and bridges potential gaps in health service, by assigning each Service member to a Transitional Support Facilitator. The facilitators, licensed behavioral health clinicians who specialize in coaching, remain with the Service member (with a 24/7 network back-up) until the transition to a new provider is complete.

Two studies have been designed to increase the basic knowledge of issues important to the psychological health of Service members. The first, which is currently underway, will identify the various factors that contribute to a mental health professional's decision to either enlist or leave military service. This study will inform the development of policies to successfully mitigate loses in active duty providers. The second is a study to improve deployment-related primary care assessments of PTSD and mental health conditions. Preliminary approval for this study has already been received.

Approximately $6.1 million was obligated to help eliminate transitional gaps in care in FY 2008.

To ensure early identification and intervention of mental health and TBI issues, the Department enhanced post-deployment assessments and reassessments, and in July 2008, also began conducting baseline neuro-cognitive assessments on Active and Reserve personnel prior to deployment.

To facilitate the continuity of care for veterans and Service members, we implemented a common DoD/VA post-deployment TBI assessment protocol, which will allow clinicians across the enterprise to collect and access the same information.

We also designed and implemented the Mental Health Self Assessment Program, which offers Service personnel and their families the opportunity to identify their own

symptoms and access assistance before a problem becomes serious. The self-assessments address PTSD, depression, generalized anxiety disorder, alcohol use, and bipolar disorder, and may be taken anonymously online, over the phone, or at special events held at installations. After completing a self-assessment, individuals receive referral information that includes services provided by TRICARE, Military OneSource, and VA Vet Centers. More than 37,000 military and family members have accessed the anonymous web- and phone-based mental self-assessment program since it was introduced in 2006.

Approximately $59.9 million was obligated for early identification and intervention of mental health issues in FY 2008.

Improving care and outcomes associated with traumatic brain injuries and PTSD requires a commitment to research in funding breakthrough prevention, detection, diagnostic and treatment modalities.

The Department is building a network in which to leverage and/or direct medical and cross-functional research that will enhance outcomes of psychological health and TBI patients.

For example, at the request of the Service Vice Chiefs of Staff and the Surgeons General, the MHS will sponsor an expedited, intramural (DoD facilities), multi-center randomized clinical trial of hyperbaric oxygen (HBO2) therapy in chronic and mild-to-moderate TBI.

The study, which is in the advanced development phase, will answer important questions regarding efficacy in this population, including whether HBO2 therapy should be provided to service members when indicated. Currently, the study is awaiting approval by the Food and Drug Administration (FDA).

We also participated in blast mitigation studies through and with the United States Army Medical Research and Materiel Command, and are working with external groups, such research universities as the Massachusetts Institute of Technology and Virginia Tech, and the National Football League, to explore new ways to mitigate the effect of blast and blunt trauma on our populations.

Together with ongoing research activities supported by the Joint Improvised Explosive Device Defeat Organization, and the Institute of Soldier Nanotechnology, we have learned a great deal about how to keep our Service members safe before, during, and after physically traumatic events.

In addition, in FY 2007 to 2008, the Department executed more than $446.5 million in Research Development, Testing, and Evaluations appropriations to further science in the areas of TBI and psychological health, including:

- Basic research directed toward gaining greater understanding of the brain and how it works;
- Applied research to provide more in-depth knowledge of TBI and psychological health prevention, treatment, diagnosis, and recovery techniques;
- Advanced technology development to create new tools, technologies, pharmaceuticals and devices, and treatment protocols to improve prevention, diagnosis, treatment and recovery;
- Clinical trials to demonstrate the safety, toxicity, and efficacy of candidate pharmaceuticals, prototype medical devices, or protocols benefiting patients diagnosed with TBI or mental health conditions; and
- Complementary and alternative medicine approaches to the treatment of PTSD and TBI, such as yoga or acupuncture.

Of course, despite the significant gains that have been accomplished, more work remains. We will continue to work with our partners to eliminate gaps; ensure the quality and consistency of care; meet the needs of Reserve forces, especially those in underserved areas; improve efforts to recruit and retain high quality mental health providers; reduce the rate of suicide, improve our ability to share and exchange data with the VA; and continually seek new ways to expand our knowledge and improve our ability to care for Service members, veterans and families.

Healthy and Resilient Individuals, Families and Communities

In addition to the measures cited above, the Department is implementing a range of policies to strengthen resilience to psychological stress and traumatic events and create healthy and resilient individuals, families and communities. These policies include removing or mitigating organizational risk factors, bolstering resilience characteristics in our Service personnel, and strengthening family wellness.

To reduce the stigma associated with mental health issues, we mounted a pro-resilience and anti-stigma campaign, and established a number of effective outreach and educational initiatives to increase "psychological fitness" through resilience building programs. We also eliminated the requirement to divulge combat-related mental health history on security clearance forms.

With the assistance of the Service Vice Chiefs, the MHS began development of the *"Real Warriors, Real Battles, Real Strength"* campaign, mentioned earlier[2], which stresses the impact of war on Service personnel, and emphasizes that seeking help for psychological concerns is a sign of strength. Supporting initiatives have been implemented across the Services to target their individual cultures.

[2] Page 6.

The MHS also helped develop educational tools to help families, especially children, cope with deployed parents or loved ones.

One exciting initiative in this area is "SimCoach," a program currently under development that will allow warriors and families to electronically query top experts in psychological health and TBI, and discuss their injuries with their peers.

Specifically targeted to the Armed Forces younger population, SimCoach will combine the best of simulation, advanced gaming technology, artificial intelligence, and avatar-based computer interaction to encourage warriors and their families to initiate treatment or access educational resources, and to reduce the stigma associated with seeking psychological health care.

Approximately $32.2 million was obligated to strengthen resilience to psychological stress and traumatic events, and to reduce the stigma associated with mental health issues in FY 2008.

The Department has also initiated a number of programs that address the adverse effects of tobacco, alcohol, obesity, and inactive lifestyles on health.

For example, the "Healthy Lifestyles Initiatives" are evidence-based projects designed to reduce tobacco use, obesity, and alcohol abuse among both active and non active duty beneficiaries.

"Quitline," is a 24/7 telephone-based tobacco cessation counseling program that offers web-based support, educational program, and pharmacotherapy. Both preliminary and final demonstration study results indicated increases in cessation rates at the end of each quarterly milestone.

The Program for Alcohol, Training, Research and Online Learning, or "PATROL," is a promising web-based, alcohol abuse pilot project that targeted young, active duty Service members on eight military installations. One month after rollout, participants in one study reported a significant reduction in heavy and binge drinking – results that were sustained in a six-month follow-up.

To help determine how best to encourage MHS beneficiaries to obtain preventive services, the TRICARE Management Activity (TMA) held a summit with experts from both the civilian and government sectors in early 2008. A variety of different pay for performance/prevention initiatives was discussed, along with strategies to determine their overall effectiveness. The National Defense Authorization Act (NDAA) for Fiscal Year 2009 codified these efforts to improve the health status of active duty members, retirees, and their family members.

- We are within 90 days of fully implementing the change to the TRICARE benefit by removing potential financial barriers to receiving certain preventive services and waiving all copayments for preventive services, including colorectal, breast, cervical, and prostate cancer screening, immunizations and visits for children less than six years of age. This also ensures that non-Medicare eligible beneficiaries pay nothing for preventive services during a year, even if the annual deductible amount has not been met.

- TMA has designed a demonstration project to assess the effects of providing incentives, along with wellness programs and care management, on healthy behaviors and lifestyle practices among non-Medicare eligible retired beneficiaries and their family members.

  This project will be conducted in three geographic area of the United States for non-Medicare eligible, TRICARE Prime retirees. Participants will receive a self-reported health risk assessment (HRA), and physiological and biometric measures, that include assessment of blood pressure, glucose level, lipids, nicotine use and weight determination. As an incentive to full participation in this project, enrollees will be eligible to receive a waiver of 50 percent of their annual TRICARE Prime enrollment fee (a $230/family annual savings).

  Information obtained from the project will be used to provide targeted interventions that help prevent, manage and improve any chronic conditions identified in the enrollee throughout the three year demonstration period. Participants will retake the HRA annually to reassess their health behaviors and outcomes.

- In order to establish a comprehensive Smoking Cessation Program under TRICARE that builds upon initiatives that had already begun, and makes available, at no cost to the beneficiary, pharmaceuticals used for smoking cessation through the mail-order pharmacy (TMOP) program, TMA has drafted a change in regulations to allow TRICARE to dispense over the counter medications from the TMOP, and to waive copayments for these medications. In addition, TMA is working diligently to contract for a 24/7/365 quit line that will be accessible for counseling world-wide, and anticipates this will be operational by the fall of 2009.

  TMA is obligating a demonstration project, through December 31, 2011, to evaluate the efficacy of providing an annual allowance to members of the Armed Forces to determine if this would increase their use of preventive health services for themselves and their family members. In this demonstration up to 1,500 members from each Service are eligible to participate. Half of the Services members are single; half have family members. Each Service will pay a preventive health services allowance of $500 per year to single members, and $1,000 per year to members with families.

AHLTA, DoD's standard global electronic health record and clinical data repository, is also enhancing efforts to build healthy communities by creating a life-long, computer-based patient record and health information to support the entire continuum of health care.

Since the Departments of Defense and Veterans Affairs share a significant amount of health information for patient being treated by both departments, AHLTA also enhances continuity of care, especially for those in transition.

To keep pace with evolving requirements and advances in technology, AHLTA is being deployed in phases or "blocks" of increasing functionality. Block 1, deployed worldwide in December 2006, provides the foundation of system performance through a graphical user interface for real-time ambulatory encounter documentation. Through AHLTA, the electronic medical records of MHS beneficiaries are retrievable at the point of care, whether the care is delivered at one of more than 880 fixed military medical and dental facilities, on board select ships, or in a deployed medical facility. On average, AHLTA processes over 135,000 encounters per workday. As of May 1, 2009, AHLTA had processed and stored over 107 million outpatient encounters.

AHLTA Theater (AHLTA-T) is operational in Iraq, Kuwait and Afghanistan. AHLTA-T collects outpatient encounters which are sent to the Theater Medical Data Store (TMDS) and AHLTA Clinical Data Repository for use in AHLTA worldwide. As of March 31, 2009, 2.2 million theater outpatient clinical encounters had been documented and transferred to AHLTA. Both DoD and VA health care providers use the Bidirectional Health Information Exchange to access theater medical information.

Currently, DoD and VA share a significant amount of health information for common patients including pharmacy data, allergy data, laboratory results, radiology reports, provider notes and procedures, problem lists, vital signs, family and social history, and digital radiology images at some sites. The Departments expect to achieve electronic health record interoperability by September 30, 2009.

Additional improvements and enhancements of AHLTA are planned for the fourth quarter of FY 2009. Key features will include automated clinical practice guidelines; a faster clinical encounter documentation process; electronic signature capabilities, so that patients can sign consents and other forms electronically; health assessment management tools, to allow patients to self-report patient history information online for storage in AHLTA; and multi-site user account access for mobile providers.

AHLTA Block 2 integrates robust dental charting and optometry support capabilities. The MHS is also developing an enterprise-wide document and image management capability, targeted for the 2nd Quarter of FY 2010, that will incorporate non-text information into AHLTA.

Currently, AHLTA's inpatient documentation capability is operational at many of DoD's largest military treatment facilities (MTF), and covers more than 50 percent of DoD's inpatient workload. Within one year, DoD plans to deploy to additional inpatient sites which will cover approximately 90 percent of DoD inpatient beds.

The Department will continue to enhance AHLTA's performance, reliability and usability and work toward our primary goal of creating a virtual lifetime electronic health record to efficiently support the processes and workflow needs of end-users.

Highest Quality and Cost Effective Care

Our final goal – providing the highest quality care and cost effective care at the lowest possible cost to the taxpayer – is every bit as important as the others I've just outlined. Military and civilian leaders, as well as the American people, rightly expect us to simultaneously provide outstanding health care to beneficiaries and efficiently manage the cost of care. While it is impossible to include all of the actions we have taken to reduce the cost of care, I can provide a good overview of the most significant.

BRAC recommendations have improved the use and distribution of military medical facilities nationwide by reducing unnecessary infrastructure, consolidating medical facilities, and providing more robust platforms for Graduate Medical Education.

Other ways we are addressing cost effectiveness include:

- Implementation of Federal Ceiling Pricing of retail pharmaceuticals. This regulation requires manufacturers to refund a portion of the cost pharmaceuticals dispensed in the retail setting. Discounts are approximately 24 percent of the non-Federal average manufacturers' price. The Department will begin receiving these rebates under this provision beginning May 26, 2009.

- Obtaining significant discounts for pharmaceuticals at MTFs and mail-order venue.

- Effective Contracting Strategies. We have reduced administrative costs through effective TRICARE contracting strategies. Efforts to further enhance the next generation of the TRICARE contracts are well underway.

- Additional increases in VA and DoD sharing of facilities, capabilities, and joint procurements.

- Introduction of new prime vendor agreements that will lower the costs of MTF medical and surgical supplies. The MHS has aggressively negotiated preferential pricing with medical-supply vendors across the country, and we project a cost avoidance of $28.3 million.

Using our strategic planning tool, the Balanced Scorecard, we are identifying the most critical mission activities, and then applying the continuous process improvement methodology to create a data-driven, decision-making culture for process improvement. The Service Surgeons General have aggressively incorporated this methodology into their business operations, and we are already witnessing positive results. We have also hired a nationally recognized expert in Lean Six Sigma to help facilitate integration of the National Capital Area and San Antonio under our BRAC work.

In fall 2006, based on recommendations from local-level MHS leaders, we began the Innovations Investment Program, to identify the best practices in place at select MTFs, or best practices utilized by private-sector health care firms and introduce them to DoD on a global scale. The intent of this program is to accelerate the use of best practices, using a joint-service, interdisciplinary team of experts to evaluate, validate and then implement proven approaches to better health care delivery. We are currently evaluating three initiatives under this program.

The 2009-2011 VA/DoD Joint Strategic Plan will improve the quality, efficiency, and effectiveness of benefits and services to veterans, service members, military retirees, and their families. For example, 113 VA medical facilities partner with 137 MTFs for a total of 323 direct sharing agreements in the delivery of 158 unique services. In FY 2008, VA and DoD joint national contracts for pharmaceuticals avoided approximately $115 million in costs.

Another example is the DoD/FDA Shelf Life Extension Program (SLEP) for pharmaceuticals. The VA used the program to extend the expiration dates on products in its Emergency Pharmacy Service program at estimated cost avoidance to VA of more than $214 million in FY 2008.

Beneficiary Satisfaction

Madam Chairwoman, we studiously seek feedback from our MHS beneficiaries, and I'm pleased to say that they continue to give the TRICARE program solid marks in satisfaction in all of our key inpatient, outpatient and population-based surveys. These surveys are based on the Consumer Assessment of Healthcare Providers and System surveys to enable us to compare our results to U.S. civilian health care surveys.

We fared well on the 2007 American Customer Satisfaction Index survey produced by the University of Michigan and other groups who rate satisfaction with the federal government. Participants rated satisfaction with inpatient care at DoD medical centers at 89 percent, the second highest satisfaction score by federal agencies/departments surveyed in the benefits-recipients segment.

MHS users' overall satisfaction with the TRICARE health plan rose from 44 percent in 2001 to 59 percent in 2008. Considering that the survey covers the entire period the Nation has been at war, with all of its accompanying stress that is a remarkable achievement.

On the monthly TRICARE Outpatient Satisfaction Survey, the six key metrics of outpatient satisfaction all increased slightly, while a survey of MHS beneficiaries' overall satisfaction with providers was 85 percent, higher than the civilian benchmark at 81 percent.

Other survey results, such as the one for the TRICARE Mail Order Pharmacy (TMOP) show that the military community has been consistently satisfied with the delivery of health care services through our partners, and we will continue to ensure that these private sector providers are rewarded for the outstanding care they deliver to our beneficiaries.

In addition to soliciting general beneficiary feedback regarding use and satisfaction with TRICARE, our surveys are also used to assess specific program performance.

For example, we surveyed National Guard and Reserve members and their families and compared those who purchased the TRICARE Reserve Select (TRS) benefit to those who did not.

We found that TRS enrollees reported the same or better access and satisfaction compared to their Selected Reserve counterparts who use their other health insurance. Specifically, TRS enrollees were more likely to report quick access to care, good communication with providers, and higher levels of satisfaction with overall health plans and health care.

In addition, TRS enrollees who use the TRICARE Standard/Extra benefits option did not differ from regular component Standard and Extra users on most aspects of access and satisfaction.

Despite these positive survey results, the MHS leadership recognizes the continuing challenge of providing timely, consistent access to care at our installations. This is a high priority for the MHS in the year ahead.

Madame Chairwoman, these are some of the more significant accomplishments the Military Health System has achieved with the resources already provided by Congress and the American people. I'd like to now highlight the key components of our budget request for FY 2010.

UNIFIED MEDICAL BUDGET REQUEST FOR FY2010

The Military Health System (MHS) is uniquely different from any other health care system. The MHS delivers preventive medicine, disease management, treatment, rehabilitation, public health, dental care, medical research, and a host of other services too numerous to list, in virtually every possible environmental condition around the globe. For many of these services, there is no civilian comparison.

The MHS works to enhance its deployable medical capability, the medical readiness of the force, and homeland defense by effectively focusing on products, processes, and services. We strive to anticipate the needs of Commanders and Service members and respond with innovative solutions, new opportunities, and high performance services and products. We have adopted a renewed emphasis on research and development infrastructure to rapidly design, develop, and deploy solutions for the warfighter, and especially to ensure that wounded warriors receive the best possible care, treatment, and support. Achieving these goals is challenging due to stress on the medical force as a result of continuing operations, a growing and aging patient population, and higher than anticipated medical cost growth.

The MHS augments care at military treatment facilities with the TRICARE health benefit. TRICARE provides eligible beneficiaries with access to a global network of private-sector healthcare providers, hospitals, and pharmacies. The MHS provides a world-class health benefit at a reasonable cost to the Department. We continue to see demand for TRICARE benefits grow, with a commensurate increase in the associated costs.

The Defense Health Program (DHP), the appropriation that supports the MHS, is under mounting financial pressure. As a result of the benefits added but Congress and beneficiaries returning to TRICARE as their primary benefit, the DoD health care financing requirement has more than doubled since 2001 – from $19 billion to $44 billion in FY 2009.

The majority of DoD health spending supports health care benefits for military retirees and their dependents, not the active force. We project that up to 65 percent of DoD health care spending will be going toward retirees in FY 2011 – up from 45 percent in FY 2001. As civilian employers' health costs are shifted to their military retiree employees, TRICARE is seen as a better, less costly option and they are likely to drop their employer's insurance. By 2015, at the current trend, DoD health care costs are projected to reach $64 billion, or 11.3 percent of the DoD budget, versus 8 percent today.

Despite these fiscal challenges, the FY 2010 budget request provides realistic funding for projected health care requirements. I would like to highlight several key attributes of this budget submission. First, the budget does not include any benefit reform savings, and beneficiary enrollment fees and co-pays remain unchanged. Second, Military Treatment Facility efficiency savings previously assumed have been fully restored to the Services Medical Departments. Finally, previously programmed military–to-civilian conversions are being restored in accordance with the provisions of the FY 2008 National Defense Authorization Act. Pursuant to this restoral, the services have submitted memorandums of agreement to restore 5,443 billets in FY 2010.

The FY 2010 Budget Submission reflects several areas of emphasis. While we have achieved outstanding success in managing injuries on the battlefield and preparing wounded Service members to live productive lives, much work remains to be done to help America's injured warriors return to full duty or to move on to the next phase of their lives.

The MHS will continue its efforts to improve diagnosis and provide compassionate care for traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD), illnesses that have presented significant challenges in providing responsive, coordinated, patient-centered healthcare. The FY 2010 budget request includes funding to support organizations, like the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and Defense Vision Center of Excellence, to overcome these challenges.

The Unified Medical Budget, the Department's total request for health care in FY 2010, is $47.4 billion. This includes the Defense Health Program; Wounded, Ill and Injured Care and Rehabilitation; Military Personnel, Military Construction, and Medicare-Eligible Retiree Healthcare.

Defense Health Program

The largest portion of the request, or $27.9 billion, will be used to fund the Defense Health Program (DHP), which is comprised of Operation & Maintenance (O&M), Procurement and Research, Development, Test & Evaluation (RDT&E).

- $27 billion is for Operation and Maintenance, which funds most day-to-day operational costs of healthcare activities;
- The Defense Health Program budget also includes $0.3 billion for equipment and systems procurement; and $0.6 billion for military relevant medical research, double that of last year's request, to advance the state of medical science, and to develop world class medical products and capabilities to improve survivability and quality-of-

life.

It is worth noting that we are requesting an additional $0.4 billion (included in the $0.6 billion above) in medical RDT&E funding to be used to advance the state of medical science, technologies, and practices in those areas of most pressing need and relevance to today's battlefield experience. Early emphasis will be on psychological health, traumatic brain injury, prosthetics and rehabilitation, restorative eye-care, poly-trauma and supporting medical information and training systems. Research projects will be selected for funding using a competitive process where Department of Defense researchers, industry and academia will submit proposals for specific research and development projects. By using this process we believe the most promising and expedient medical solutions will be developed and fielded for the Joint Force.

Military Personnel and Construction

For Military Personnel, the Unified Medical Budget includes $7.7 billion to support the more than 84,000 military personnel who provide healthcare services in military theaters of operations and fixed health care facilities around the world. These services include medical and dental care, global aeromedical evacuation, shipboard and undersea medicine, and global humanitarian assistance and response.

Funding for medical Military Construction includes $1.0 billion for 23 medical construction projects in 16 locations, including two of the Department's highest construction priorities: Phase 1 of a Hospital Replacement Project in Guam, and Phase 1 of a new Ambulatory Care Center at Lackland Air Force Base, Texas.

DoD Medicare-Eligible Retiree Health Care Fund

The estimated normal cost of the Medicare-Eligible Retiree Health Care Fund in FY 2010 is $10.8 billion. This funding includes payments for care in military treatment facilities, to private health care providers, and to reimburse the Services for military labor used in the provision of health care services.

Wounded Ill and Injured

The Department of Defense has, and will continue to provide, world class health and rehabilitative care for all Service members who are wounded, ill or injured as a result of their service to our country.

The FY 2010 DoD budget request includes $3.3 billion for enhanced care for wounded, ill or injured Service members, new infrastructure to house and care for them, and research efforts to mitigate the effect of psychological health and traumatic brain injuries.

The DHP budget request includes $1.7 billion of the total DoD request. A major focus of the budget for FY 2010 is to ensure that all medical requirements associated with wounded warrior healthcare, to include traumatic brain injury and psychological health are addressed.

The Service medical departments, along with the TRICARE Management Activity, presented requirements and the Secretary fully funded all medical requirements requested. No additional requirements are anticipated at this time.

CONCLUSION

Madam Chairwoman, I began my statement with a quote from the Secretary of Defense that epitomizes the Military Health System's commitment to the health and well-being of our forces and their families. I'd like to end by quoting one of the many wounded warriors who epitomize the will and fighting spirit of the men and women who so proudly and selflessly defend the freedoms we enjoy every day.

Lieutenant Jason Redman is a Navy SEAL who was part of an elite Special Ops team in Iraq last year when he took rounds from a machine-gun in his face and arm. Jason posted a bright orange sign on the door of his hospital room at Bethesda National Naval Medical Center. It read:

"Attention to all who enter here. If you are coming into this room with sorrow, or to feel sorry for my wounds, go elsewhere. The wounds I received I got in a job I love, doing it for people I love, supporting the freedom of a country I deeply love.

"I am incredibly tough and will make a full recovery. What is full? That is the absolute utmost, physically, my body has the ability to recover. Then I will push that about 20 percent further through sheer mental tenacity.

"This room you are about to enter," he wrote, "is a room of fun, optimism, and intense rapid regrowth. If you are not prepared for that, go elsewhere."

Madame Chairwoman, that is what the Military Health System is all about – Doing the very best we can for these men and women who give everything they have for every one of us. We can never fully repay them for the sacrifices they make for our country and our future as a free people, but we can and will continue to do everything we can to heal their wounds and honor their courage and commitment to the country we all love.

Thank you again, Madame Chairwoman, for the opportunity to be with you today. I look forward to your questions.

UNCLASSIFIED

FINAL VERSION

STATEMENT BY

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COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

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DEFENSE HEALTH PROGRAM OVERVIEW

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Madam Chairwoman, Representative Wilson, and distinguished members of the Subcommittee, thank you for providing me this forum to discuss Army Medicine and the Defense Health Program. I appreciate this opportunity to talk with you today about some of the very important work being performed by the dedicated men and women—military and civilian—of the U.S. Army Medical Department (AMEDD) who personify the AMEDD value "selfless service." In recognition of 2009 being "The Year of the NCO", throughout my testimony I will highlight the contributions of the AMEDD's Non-Commissioned Officer Corps, the backbone of Army Medicine. Non-Commissioned Officers comprise 18% of the Army Medical Department and play critical roles in every aspect of the organization. I am joined today by the senior enlisted medic in the Army, my Command Sergeant Major Althea Dixon, one of the finest Soldiers and leaders with whom I have had the privilege to serve and an invaluable member of my command team.

As the Commander of the U.S. Army Medical Command (MEDCOM), I oversee with the assistance of Command Sergeant Major Dixon a $10 billion international healthcare organization staffed by 70,000 dedicated Soldiers, civilians, and contractors. We are experts in medical research and development, medical logistics, training and doctrine, the critical elements of public health--health promotion and preventive medicine, dental care, and veterinary care--in addition to delivering industry-leading health care services to 3.5 million beneficiaries around the world. But central to everything we do in Army Medicine is the warfighter—we exist as a military medical department to support the warfighter. I am happy to report that we are accomplishing that mission phenomenally well. I can say this with great confidence after spending the first week of March with the US Central Command (CENTCOM) Surgeon at the Multi-National Force/Multi-National Corps-Iraq Surgeon's Conference in Iraq. Seeing first hand the care and civil-military medical outreach from Brigade and Division to Corps and Theater was a clear demonstration of the Joint Medical Force

providing top-notch medical support across the full-continuum of care and nation building.

To determine how successful we are at executing our mission, Army Medicine uses the Balance Scorecard (BSC) approach developed in the 1990s by Harvard's Doctors Robert Kaplan and David Norton. Simply put, the BSC serves as an organizational strategic management system which can help us improve organizational performance while we remain aligned to our strategy. The MEDCOM began BSC implementation in 2001 under LTG (Ret) James Peake's leadership. Since then, we have continued to refine the BSC to grow and direct our dynamic organization. I use the enclosed Army Medicine Strategy Map (published in April 2008 and revised in January 2009) and Scorecard as the principal tool by which to guide and track the Command as it improves operational and fiscal effectiveness, and better meets the needs of our patients, customers, and stakeholders. The BSC communicates to our MEDCOM workforce; drives top-to-bottom organizational understanding and alignment; and focuses our day-to-day efforts to ensure we execute our Mission successfully.

The Army Medicine BSC measures and improves organizational performance in four "balanced" Strategic Perspectives: "Resources" and "Learning and Growth" which are the "Means"; "Internal Processes" which are the "Ways"; and "Patients, Customers and Stakeholders" which are the "Ends" by which we show best value in products and services. These "Ends" are how I have organized my statement in order to best communicate the significant and varied accomplishments of Army Medicine over the last year.

The Six Army Medicine "Ends"

1.0 Improved Healthy and Protected Families, Beneficiaries, and Army Civilians

2.0 Optimized Care & Transition of Wounded, Ill, and Injured Warriors

3.0 Improved Healthy and Protected Warriors

4.0 Responsive Battlefield Medical Force

5.0 Improved Patient and Customer Satisfaction

6.0 Inspire Trust in Army Medicine

1.0 Improved Healthy and Protected Families, Beneficiaries, and Army Civilians - Improve the health of beneficiaries thru cost-effective evidence-based care, proactive disease management, demand management, and public health programs.

Use of HEDIS^{R} Measures – The Healthcare Effectiveness and Data Information Set (HEDIS^{R}) is a tool used by more than 90% of America's health plans (> 400 plans) to measure performance on important dimensions of care. The measures are very specifically defined, thus permitting comparison across health plans. The Department of Defense (DoD) is not a member of the HEDIS program, but uses the HEDIS methodology to measure and compare its performance to the HEDIS benchmarks. The Military Health System (MHS) Population Health Portal takes administrative data and electronic health record data and provides reports on the status of our beneficiaries on each measure. Currently, we track 9 measures and compare our performance to HEDIS benchmarks. In October 2008, the Army was in the 90th percentile compared to HEDIS health plans for 2 of 9 measures. We are in the 50th to 90th percentile for 6 measures and below the HEDIS 50th percentile for one measure. Marked improvement has been seen in colorectal cancer screening which improved 8.9% from October 2005 to October 2008 and approaches the HEDIS 90th percentile. In addition, the Army has very high compliance with Pneumovax, the vaccine against pneumococcal pneumonia, for our enrolled patients over age 65. Since 2007, we've been providing financial incentives to our hospitals for superior compliance in key HEDIS measures. The Army was the pioneer for what the Assistant Secretary of Defense for Health Affairs is now terming Pay-for-Performance. We have shown that these incentives work to change behavior and achieve desired outcomes in our system.

MEDCOM Reorganization - The MEDCOM is engaged in a phased reorganization designed to optimize the delivery of healthcare to our Army and to support a deploying force. With the support of senior Army leadership, I approved phase one of this reorganization which aligns CONUS Regional

Medical Commands (RMCs) with their supporting TRICARE regions. MEDCOM is restructuring in order to be better aligned and positioned to support our transforming Army. Command Sergeant Major Matthew T. Brady was instrumental in developing the structure and functions for the newly designed Western RMC headquarters, and his contributions are emblematic of the significant role played by NCOs across the MEDCOM in our restructuring efforts.

Healthcare support today is outstanding and it must remain so for our Army to succeed during an era of persistent conflict. As the Army changes its structures, relationships and organizational designs through transformation and other initiatives to better support our Nation in the 21st Century, the AMEDD must adapt to ensure it remains reliable and relevant for our Army. The main restructuring is from 4 CONUS RMCs to 3 CONUS RMCs. While reorganizing RMCs, we intend to further integrate healthcare resources, capabilities and assets to foster greater unity of effort and synergy of our healthcare mission. The restructuring will posture us to better provide the best support for Army Force Generation (ARFORGEN) and improve readiness through enhanced health care services for our Soldiers, their Families, and Army units.

Clinical Information Systems - The AMEDD has long recognized a need for an information system to help us grow as a knowledge-driven organization. The AMEDD energetically assumed service lead for the DoD during the implementation of the Composite Health Care System II (CHCS II), now known as AHLTA. Unfortunately, AHLTA has not always kept pace with expectations at the user-level or at the corporate level for data mining and other uses. The Army has taken significant steps to leverage the data from AHLTA and other clinical information systems to improve clinical quality and outcomes as well as patient safety. To address identified shortcomings with AHLTA at the provider level, the AMEDD has invested in the MEDCOM AHLTA Provider Satisfaction (MAPS) initiative. This includes investment in tools like Dragon Medical™ and As-U-Type®, individualized training and business process re-engineering led by clinical champions, and the use of wireless and desktop virtualization. At the Heidelberg Health Center in Germany, Staff Sergeant Kenneth M. Melick is the workhorse

who took the physicians' vision for business process reengineering from construction to final implementation and ensured success. MAPS is beginning to show significant improvements in provider usability and satisfaction. Direct interviews with providers and staff reveal that MAPS implementation has generated a dramatic change in attitude among our staff.

The most recent version of AHLTA has presented us with challenges, but it is showing improvements and gaining provider acceptance. AHLTA provides significant benefit to beneficiaries, especially in the areas of patient safety, security, improved clinical and readiness outcomes, and global availability of records. In addition, a new enterprise architecture for the MHS will likely result in a significant improvement in managing our information systems. The next update to AHLTA (version 3.3) is being deployed and its additional functionality and improved speed is well-liked by the providers who have tested it.

Force Health Protection and Public Health Programs – The US Army's Center for Health Promotion and Preventive Medicine (CHPPM) is a subordinate command of the MEDCOM that affects the lives of Soldiers and Families everyday. Its mission is to provide worldwide technical support for implementing preventive medicine, public health, and health promotion/wellness services into all aspects of America's Army and the Army community. The CHPPM team supports readiness by keeping Soldiers fit to fight, while also promoting wellness among their Families and the Federal civilian workforce. CHPPM integrates public health efforts to develop and export primary prevention based products by using epidemiologic data of disease and injury to identify the best prevention programs to implement for overall population health improvement. One member of the CHPPM team--Sergeant Kerri Washington--made a notable impact on the health and safety of our US Army and Iraqi Forces in the Multi National Division – Baghdad area of responsibility. Sergeant Washington deployed as a Preventive Medicine (PM) Specialist with the 61st Medical Detachment (PM) and applied his preventive medicine skills, leadership ability, and unique health surveillance training to enhance Soldier health and disease prevention.

CHPPM is establishing a Public Health Management System to evaluate the programs and policies developed to promote optimal health in the Army community. This system will use the public health process to provide metrics indicating the success or lack of success in these endeavors. This will allow leaders to make informed decisions on effective or ineffective public health issues in the Army. Army veterinarians play a key role in public health as well, ensuring the safety of food and water and the prevention of animal-borne diseases. As part of the MEDCOM Reorganization addressed earlier, I have directed my staff to assess the feasibility and benefits of establishing a Public Health Command to better synchronize and integrate the efforts of all AMEDD members who contribute to public health programs. This will enhance comprehensive health and wellness and optimize delivery of public health support to the Army.

2.0 Optimized Care & Transition of Wounded, Ill, and Injured Warriors

Warrior Care and Transition Program - The transformation of U.S. Army Warrior Care began in April 2007 with the development of the Army Medical Action Plan (AMAP), which outlined an organizational and cultural shift in how the Army cares for its wounded, ill, and injured Soldiers. Over the past 23 months, the AMAP has evolved into the Army Warrior Care and Transition Program (WCTP), fully integrating Warrior Care into institutional processes across the Army, and is achieving many of the Army's goals for enhancing care and improving the transition of wounded warriors back to duty or into civilian life as productive veterans. At the heart of the WCTP is the successful establishment of 36 Warrior Transition Units (WTUs) at major Army installations worldwide, and nine Community Based Warrior Transition Units (CBWTUs) located regionally around the U.S. These units replace the Medical Holdover (MHO) system of the past and provide holistic care and leadership to Soldiers who are expected to require six months of rehabilitative treatment and/or need complex medical case management.

Comprehensive Transition Plan – In our first year of Warrior Care and Transition, we heavily invested in the structure of our units and support systems. Now in our second year, we recognize that our focus needs to be on optimizing the transition for our Soldiers. In March 2008, MEDCOM launched the Comprehensive Transition Plan initiative for Warriors in Transition. Instead of focusing solely on the injury or illness, the Comprehensive Transition Plan fosters a holistic approach to a Warrior's rehabilitation and transition. This is accomplished through the collaboration of a multidisciplinary team of physicians, case managers, specialty care providers, and occupational therapists. Together with the Soldier, they develop individually tailored goals that emphasize the transition phase to civilian life or return to duty. Goals are set and the transition plan developed within one month of the Soldier's arrival at the WTU.

Physical Disability Evaluation System - The Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) processes have been streamlined and paperwork requirements reduced to more efficiently move a Soldier's disability package through the adjudication process. Additionally, collaboration between the DoD and the Department of Veterans Affairs (VA) ensures that claims from Warriors in Transition are processed by the Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) 60 to180 days prior to separating so that they can receive their VA benefits and health care immediately upon discharge. General Frederick M. Franks, Jr., USA Retired has been leading an Army task force to research and recommend improvements to the MEB/PEB process. His findings, which were recently delivered to the Secretary of the Army, recommended that DoD and VA eliminate dual adjudication from the current system and "transition to a comprehensive process focusing on rehabilitation and transition back to either uniformed service or civilian life that promotes resilience, self-reliance, re-education, and employment, while ensuring enduring benefits for the Soldier and Family." This finding reaffirms the importance of the Comprehensive Transition Plan.

WTU Staff Training – Included in the AMAP was the development of standardized training for the staff of WTUs. The US Army Medical Department

Center and School (AMEDDC&S) quickly developed an online orientation course for distribution to all staff. In October 2008, the first iteration of a 2-week resident course was conducted. As of May 2009, five classes have been conducted with 486 graduates. The course is designed for newly assigned Squad Leaders, Platoon Sergeants, and Nurse Case Managers (NCM). The mission is to provide education, skills, and tools that can enable them to positively affect the healing and transition of the Warriors and their Families through more compassionate leadership and specialized case management. The course is managed and directed by Ms. Sherri Emerich, a passionate education specialist and veteran of Desert Storm, combined with the subject matter expertise of Master Sergeant Brian Thomas, who was dynamic in the conception of the Fort Dix WTU, as well as development of some of the best practices still in use today. A 1-week training workshop is currently under design for the Primary Care Managers.

Warrior Satisfaction - Over the past two years, the Army has made tremendous progress in transforming how it provides health care to its Soldiers, with improvements impacting every aspect of the continuum of care. Over this period, overall Soldier and Family satisfaction with the care and support they have received as a result of the efforts of the WCTP has increased significantly. Two years ago, only 60% of those in the legacy medical hold units were satisfied with the care they received. Today, that number has increased to 80% of Soldiers and Families who now receive the focused and comprehensive care and support provided by WTUs. Considering that over twenty thousand Soldiers, along with their Families, have transitioned through the WCTP over that time, this represents a significant number of "satisfied" customers. A key element of increased satisfaction has been the availability of a robust ombudsman program staffed primarily with retired NCOs. An ombudsman works at each of our WTUs on behalf of the Warriors in Transition and their Families to fix problems and cut through bureaucratic entanglements. It is a great example of our dedicated senior NCOs continuing to serve Soldiers even after they have taken off the uniform.

3.0 Improved Healthy and Protected Warriors - Improve the health of service members through full spectrum health services to optimize mission readiness, health and fitness, and resiliency before, during, and after deployment.

Evidence Based Practices – The theme of evidence based practices runs through everything we do in Army Medicine and is highlighted throughout our Balanced Scorecard. Evidence based practices mean integrating individual clinical expertise with the best available external clinical evidence from systematic research. Typical examples of evidence based practice include implementation of clinical practice guidelines and dissemination of best practices. I encourage my commanders and subordinate leaders to be innovative, but across Army Medicine we must balance that innovation with standardization so that all of our patients are receiving the best care and treatment available.

Comprehensive Soldier Fitness - The Army Chief of Staff has established a vision of an Army comprised of balanced, healthy, and self-confident Soldiers and Families whose resilience and total fitness enable them to thrive in an era of high operational tempo and persistent conflict. To achieve this ambitious vision, he is instituting the Comprehensive Soldier Fitness Program. General Casey identified several shortcomings in his own Army experience. For example, the Army does not routinely assess all the elements of wellness, fitness, and optimal human performance, other than physical. Resilience, life skills, and mental coping techniques are not fully trained across the Army. The Army does not always link available life skills and performance programs and interventions with Soldiers and Families until the need has been demonstrated by a negative behavior. And the Army does not teach Soldiers about the potential for post traumatic growth, nor give Soldiers the opportunity to validate their post traumatic growth during Post Deployment assessments. The intent of the Comprehensive Soldier Fitness Program is to increase the resiliency of Soldiers and Families by developing the five dimensions of strength—physical, emotional, social, spiritual, and family. This program is in early development, but under the leadership of Brigadier General Rhonda Cornum, an AMEDD physician, and with the

commitment of passionate non-commissioned officers like her Non-Commissioned Officer in Charge, Master Sergeant Richard Gonzales, I expect this program to have a profound positive effect on the lives of Soldiers and Families.

Brain Health - Commanders and leaders are responsible for the mental and physical well-being and care of Soldiers. They play a critical role in encouraging Soldiers to seek prompt medical care for traumatic brain injuries (TBI). This responsibility begins on the battlefield, as close as possible in time and space to the injury. The AMEDD is developing the best process to evaluate and treat every Service member involved in an event that may result in TBI. Commanders and medics throughout theater are emphasizing early recognition of brain injuries followed by examinations and care rendered in accordance with clinical practice guidelines developed by the AMEDD in conjunction with the CENTCOM Surgeon. The Army is also working closely with the National Guard to implement a personnel tracking instrument that provides identification of individuals who may have been involved in a blast and require screening.

In coordination with the VA and the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, the Army continues to expand resources dedicated to TBI research and treatment. The Defense Centers of Excellence (DCoE), directed by Army Brigadier General Loree Sutton, lead a collaborative effort toward optimizing psychological health and TBI treatment for all Service members. The DCoE establishes quality standards for: clinical care; education and training; prevention; patient, family and community outreach; and program excellence. The DCoE mission is to maximize opportunities for Warriors and Families to thrive through a collaborative global network promoting resilience, recovery, and reintegration for psychological health and TBI.

Fort Campbell's Warrior Resiliency and Recovery Center for mild TBI is showing very promising results in the identification and treatment of mild TBI. The post concussive syndrome appears to exist in these Soldiers with a natural clinical history separate from that of Post Traumatic Stress Disorder (PTSD) or other psychiatric conditions. The syndrome is effectively treated with an intensive

and comprehensive interdisciplinary approach. Early data indicate significant improvement in all treated cases and complete return to duty recovery in over 77% of treated Soldiers.

Battlemind Training - One validated evidence-based practice that reduces the impact of post traumatic stress is the Battlemind Training System (BTS). The Battlemind Training System (BTS) reflects a strength-based approach, using buddy aid and focusing on the leader's role in maintaining our Warriors' mental health. The BTS targets all phases of the deployment cycle as well as the Warrior life cycle and medical education system. BTS includes training modules designed for Warriors, Leaders, and military spouses. Key teaching points about PTSD and concussion were recently incorporated into the deployment cycle and life cycle Battlemind modules.

RC Dental Readiness - Maintaining dental readiness in the Reserve Components (RC) has been challenging. During the past year, new program developments have provided an integrated Army solution for RC dental readiness throughout the ARFORGEN cycle. The Army Dental Command (DENCOM) executes First Term Dental Readiness (FTDR) at Initial Entry Training (IET) installations, and focuses on examining and treating dental conditions in recruits that could otherwise render a Soldier non-deployable. Upon graduation from IET, RC Soldiers return to their units where the Army Selected Reserve Dental Readiness System (ASDRS), initiated in September of 2008, maintains RC Soldier dental readiness throughout the three ARFORGEN phases. If the RC Soldier is mobilized, their deployment dental readiness is validated by DENCOM-operated facilities. If they are found to be deficient, they are examined and treated to bring them up to deployable standards by dedicated AC and RC dental personnel such as Sergeant First Class Dexter Leverett, a USAR NCO mobilized since 2004, who has managed RC mobilization and demobilization dental operations at both Fort Hood and Camp Shelby, MS—two sites which have processed over 12,000 RC Soldiers in the past 5 months alone. Upon return from deployment, DENCOM resets RC Soldier dental readiness by conducting a Demobilization Dental Reset (DDR) which provides a dental exam

and readiness care that can prudently be completed during the abbreviated demobilization process. Since July 2008 we have dentally reset 88% of RC Soldiers demobilizing from overseas. I expect this integrated approach to generate improved RC dental readiness.

Armed Forces Health Surveillance Center - The new Armed Forces Health Surveillance Center (AFHSC), a DoD Executive Agency supported by CHPPM, performs comprehensive medical surveillance and reporting of rates of diseases and injuries among DoD service members. AFHSC's main functions are to analyze, interpret, and disseminate information regarding the status, trends, and determinants of the health and fitness of U.S. military (and military-associated) populations and to identify and evaluate obstacles to medical readiness. AFHSC is the central epidemiological resource for the US Armed Forces, and it provides regularly scheduled and customer-requested analyses and reports to policy makers, medical planners, and researchers. It identifies and evaluates obstacles to medical readiness by linking various databases that communicate information relevant to service members' experiences that have the potential to affect their health.

4.0 Responsive Battlefield Medical Force - ensure health service assets of all three components are trained, modular, strategically deployable, and can support full spectrum operations and joint force requirements.

Pre-deployment Trauma Training – Adhering to the policy that no one should be initially exposed to a medical challenge while on deployment or on the battlefield, pre-deployment trauma training is now mandatory for individual providers and medical units to improve survival rates. It is a critical link between standard medical care and the intense battlefield environment Soldiers face in the current conflicts. By recreating the high-stress situations medics will face in Iraq and Afghanistan, this training allows for the refinement of advanced trauma treatment skills and sensitization to hazardous conditions, thereby allowing medics to increase their confidence and proficiency in treatment. This training includes a surgical skills laboratory, the principles of International Humanitarian

Law, and mild TBI and Combat Stress identification. Returning Soldiers cite this as the best training they have ever received.

Medical Simulation Training Centers - The Medical Simulation Training Center (MSTC) grew from an Army Chief of Staff directive to create and quickly implement medical simulation training to prepare combat medics for the battlefield. Command Sergeant Major David Litteral and Sergeant First Class William Pilgrim were active in the early development of the MSTC program, and are two of the many NCOs instrumental in the program's success. In Fiscal Year (FY) 2008 the 14 stateside MSTCs provided training to 27,136 Combat Medics and non-medical Soldiers in the Tactical Combat Casualty Care (TC3) and Medic sustainment courses. Also in FY 2008, at four locations within the CENTCOM Area of Responsibility (AOR), 26,132 Medics and Soldiers validated their TC3 skills and received just in time training. This success has carried into FY 2009 as 20,235 Medics and Soldiers have passed through the now 16 stateside MSTCs and four CENTCOM locations for training and/or validation of critical battlefield lifesaving skills.

Joint Forces Combat Trauma Medical Course (JFCTMC) - This is a five-day trauma training course developed by the AMEDDC&S and designed for providers deploying to Level III (Combat Support Hospital) medical missions. The course is a series of lectures with breakout sessions by specialty, which include laboratory sessions. JFCTMC prepares deploying providers to care for patients with acute war-related wounds and incorporates lessons learned from Operation Iraqi Freedom and Operation Enduring Freedom. Sergeant First Class Theresa Smith, Sergeant First Class Pearell Tyler, Sergeant First Class David Estrada, Sergeant First Class Robert Lopez, and Staff Sergeant Cedric Griggs conduct the much-praised Emergency Surgical Procedures portion of this course and provide Point of Wounding training. That's right—non-commissioned officers are training physicians and other health care providers.

Combat Development - AMEDD NCO Combat Developers, like Master Sergeant (MSG) Christian Reid and Sergeant First Class Raymond Arnold, have been front and center in product improvements to the Mine Resistant Ambush

Protected (MRAP) ambulance, Army Combat Helmet, Combat Arms Ear Plugs, Improved Outer Tactical Vest, and Fire Retardant Army Combat Uniform. Additionally, MSG Reid has been pivotal in the development of the Improved First Aid Kit (IFAK) from concept to fielding in six months as well as the Warrior Aid and Litter Kit (WALK), of which more than 25,000 have been procured to support current combat operations. The MRAP-Ambulance provides increased protection to our crews and patients. To make the MRAP-Ambulance the most capable ground ambulance in the Army today, we integrated "spin-out" technology from the Future Combat System (FCS) Medical Vehicles. The combat medic is now able to leave the Forward Operating Bases to conduct medical evacuation missions and can provide world class en-route care to wounded soldiers. The AMEDD also developed Casualty Evacuation Kits (CASEVAC) for both the MRAP and HMMV ambulances to increase capability. These efforts provided the combat medic with field ambulances built for survivability in the challenging environment of asymmetric warfare.

Fresh Blood Distribution - Recognizing that fresher blood has been associated with increased survival on massively transfused patients, the Armed Services Blood Program Office (for which Army maintains oversight as Executive Agent) has been working with the Services to decrease the time it takes for blood to arrive in theater with the overall goal of getting 80% of the units in theater by day seven. The average age of red blood cells arriving in theater prior to November 2008 was 13.3 days. Sergeant First Class Peter Maas and others in the Blood Program Office identified 13 action items necessary to improve blood collection, manufacture, and distribution to the CENTCOM AOR. Since implementing these action items in November, 2008, the average age of red blood cells arriving in theater has dropped below 9 days. The most recent shipment had an average age of 6.3 days. In the last few months, we have managed to bypass blood delivery to Bagram and are shipping blood directly to Kandahar from Qatar. This has resulted in blood reaching Kandahar that is 2-3 days fresher than before. In addition to delivering fresher blood to theater, we

are actively and aggressively pursuing new blood technologies that should lead to improved warrior care on the battlefield in the near future.

Armed Forces Institute of Regenerative Medicine - The US Army Medical Research and Materiel Command (USAMRMC) in partnership with the Office of Naval Research, the US Air Force, the National Institutes of Health, and the VA established the Armed Forces Institute of Regenerative Medicine (AFIRM) in March 2008. The AFIRM is a multi-institutional, interdisciplinary network working to develop advanced treatment options for our severely wounded servicemen and women. The AFIRM is made up of two civilian research consortia working with the US Army Institute of Surgical Research (USAISR) at Fort Sam Houston, Texas. One consortium is led by Wake Forest University Baptist Medical Center and the McGowan Institute for Regenerative Medicine in Pittsburgh and one is led by Rutgers, the State University of New Jersey, and the Cleveland Clinic. Each of these civilian consortia is itself a multi-institutional network.

Regenerative medicine, which has achieved success in the regeneration of human tissues and organs for repair or replacement, represents great potential for treating military personnel with debilitating, disfiguring, and disabling injuries. Regenerative medicine uses bioengineering techniques to prompt the body to regenerate cells and tissues, often using the patient's own cells combined with degradable biomaterials. Technologies for engineering tissues are developing rapidly, with the ultimate goal of delivering advanced therapies, such as whole organs and engineered fingers and limbs.

Joint Theater Trauma System and Joint Trauma Analysis and Prevention of Injury in Combat – The Joint Medical Force continues to show great improvements in battlefield care as a consequence of linking all information from Level 2 and 3 care through the entire continuum of care via the Joint Theater Trauma System (JTTS). The JTTS, coordinated by the Institute for Surgical Research of the USAMRMC, provides a systematic approach to coordinate trauma care to minimize morbidity and mortality for theater injuries. JTTS integrates processes to record trauma data at all levels of care, which are then analyzed to improve processes, conduct research and development related to

trauma care, and track and analyze data to determine the long term effects of the treatment that we provide. The JTTS also plays an active role as a partner in the Joint Trauma Analysis and Prevention of Injury in Combat (JTAPIC) program, another USAMRMC asset for Blast Injury Research.

The JTAPIC Program links the DoD medical, intelligence, operational, and materiel development communities with a common goal to collect, integrate, and analyze injury and operational data in order to improve our understanding of our vulnerabilities to threats and enable the development of improved tactics, techniques, and procedures (TTPs), and materiel solutions that will prevent or mitigate traumatic injuries. The JTAPIC Program has already made a difference in the way we protect our Warfighters from combat injuries as illustrated in the following key accomplishments:

- Provided actionable information that has led to modifications and upgrades to vehicle equipment and protection systems, such as seat design, blast mitigating armor, and fire suppression systems;

- Established a near-real time process for collecting and analyzing combat incident data that confirmed the presence of threat weapons of interest;

- Analyzed combat incident data to identify vulnerabilities in operational procedures, and rapidly conveyed those vulnerabilities to commanders in theater;

- Established a process for collecting and analyzing damaged personal protective equipment (PPE), such as body armor and combat helmets, to provide PPE developers with the information they need to develop enhanced protection systems.

The JTAPIC Program received the 2008 Department of the Army Research and Development Laboratory of the Year Award for Collaboration Team of the Year in recognition of its accomplishments.

Combat Medic Skills Textbook - Our combat medics (68W) are the best trained battlefield medics in the world. The historically low "died of wounds" rate is evidence of their enhanced skills. The medics of the 68W generation are trained to perform advance airway skills, hemorrhage control techniques, shock management, and evacuation. Sergeant First Class Nadine Kahla and Sergeant

First Class Jason Reisler are 68W NCOs assigned to the AMEDD Center & School. They are representative of the 17 other 68W NCO authors who contributed to the new 68W Advanced Field Craft Combat Medic Skills Textbook, a state of the art training manual for the combat medic. This delineation of combat medic skills is newly published and will be issued to every graduating combat medic beginning this month. We are currently looking at ways to distribute this textbook to every medic in the force--Active, National Guard, and Army Reserve.

5.0 Improved Patient and Customer Satisfaction - Improve stakeholder satisfaction by understanding, managing, and exceeding their expectations.

Improved Infrastructure - On behalf of the Army Medical Department team, I want to thank the Congress for listening to our concerns about military medical infrastructure and taking significant action to help us make needed improvements to our facilities. Funding provided for military hospitals in the FY2008 supplemental bill and in the American Recovery and Reinvestment Act of 2009 will positively impact the quality of life of thousands of Service Members, Family Members, and Retirees as we build new state of the art facilities in places like Fort Benning, Georgia, Fort Riley, Kansas, Fort Hood, Texas, and Fort Sam Houston, Texas. Additional funding provided by Congress for Sustainment, Restoration, and Modernization of our facilities has been put to great use and allowed us to make some valuable improvements that have been noted by our staff and patients.

The Army requires a medical facility infrastructure that provides consistent, world class healing environments that improve clinical outcomes, patient and staff safety, staff recruitment and retention, and operational efficiencies. The quality of our facilities – whether medical treatment, research and development, or support functions - is a tangible demonstration of our commitment to our most valuable assets - our military family and our MHS staff. The environment in which we work is critical to staff recruitment and retention in support of our All Volunteer Force. Not only are these facilities the bedrock of our direct care

mission, they are also the source of our Generating Force that we deploy to perform our operational mission. To support mission success, our current operating environment needs appropriate platforms that support continued delivery of the best health care, both preventive and acute care, to our Warfighters, their Families and to all other authorized beneficiaries. I am currently working closely with the Assistant Secretary of Defense for Health Affairs and the leadership of the DoD to determine the level of investment our medical facilities will need. I respectfully request the continued support of DoD medical construction requirements that will deliver treatment and research facilities that are the pride of the Department.

Access to Care - Army leadership and MEDCOM are decisively engaged in improving access to care for our Soldiers and their Families. These efforts will result in markedly improved access and continuous situational awareness at each medical treatment facility. Access means that patients are seen by the right provider, at the right time, in the right venue, and this applies equally to the Direct Care System & Purchased Care System (TRICARE). Key elements identified for improving access to care include:

- Aligning treatment facility capacity with the number of beneficiaries
- Enhancing provider availability
- Reducing friction at key points of access
- Managing clinic schedules
- Leveraging technology

We have developed a campaign plan to improve access by giving hospital commanders the tools they need along with the responsibility and accountability to generate results.

Sustainable Cost of Operations – While focusing on quality outcomes, the MEDCOM is also concerned with ensuring that we maintain a sustainable cost of operation for the AMEDD. Our efforts to improve access are coupled with initiatives to improve efficiency. Our Performance Based Adjustment Model (PBAM) provides financial incentives for improving efficiency, patient satisfaction, and quality. PBAM and other incentive programs have resulted in the Army

being the only Service to achieve planned workload gains every year since 2003. A key author of PBAM is Master Sergeant (now retired) Richard Meyer.

Disseminating Best Practices – The MEDCOM has embraced the Lean Six Sigma approach to sustaining improved performance. As an example, a Lean Six Sigma project to improve the telephone appointment process was initiated at Carl R. Darnall Army Medical Center (CRDAMC), the largest telephone appointment call center in the MEDCOM. The call center was plagued with high call volume, low patient satisfaction, long process cycle time, and high variation. The project sought to decrease process cycle time and the call abandon rate to improve patient satisfaction. By the conclusion of the project, the overall average hold time was reduced to 33 seconds (a 6-fold improvement); the call abandon rate was reduced to 3% (a 10-fold improvement); calls handled increased from 4,700 to 7,300 per week; and call agent turnover was reduced. Today the mean hold time at CRDAMC is 3 seconds. This project's successful action plan and metrics have been disseminated across the command as a best practice.

6.0 Inspire Trust in Army Medicine - Increase stakeholder support of Army Medicine by inspiring trust, building confidence, and instilling pride.

Improving civilian medical practices - The implementation of tactical combat casualty care (TC3) principals for point of injury treatment on the battlefield has changed long-standing hemorrhage control protocols in the civilian Emergency Medical Services (EMS) community. The nation's EMS community has altered long-standing treatment protocols that formerly considered tourniquet use a last resort. The use of tourniquets, based on the success of their application by military medics in theater, is now not only seen as safe by our nation's healthcare providers, but as the intervention of choice for control of severe hemorrhage. Hemorrhage control is the leading cause of death in trauma. The change in philosophy regarding tourniquet use will result in more lives saved in both urban and rural areas of our country.

Establishing Successful Interservice Partnerships (San Antonio Military Medical Center) - Wilford Hall Medical Center (WHMC) and Brooke Army Medical

Center (BAMC) are quickly evolving towards the San Antonio Military Medical Center (SAMMC), which is an integrated health care platform in which patient care is delivered in two facilities operating under one organizational structure. The SAMMC organizational structure has been operational for over a year. The organizational structures of BAMC and WHMC were both realigned to form a functional organization for delivery of health care, maintenance of our readiness and deployment platforms, sustainment of training of all levels of health care providers, and promotion of research. Many physical moves of medical services have already occurred across the SAMMC platform. SAMMC is planning for the migration of the two military level one trauma centers in San Antonio to one military level one trauma center, capable of handling the same patient care volume that is being delivered today in the two centers. Planning and coordination with the City of San Antonio have been an integral part of this process to ensure continued trauma support in the city. SAMMC enjoys strong collaborations with both the University of Texas Health Science Center, local government leaders, and the Audie Murphy Veterans Memorial Hospital in support of the large tri-service beneficiary population in the San Antonio community.

Establishing Successful Interagency Partnerships (Behavioral and Social Health Outcomes) - CHPPM resources are partnered with civilian academia, the VA and the Department of Health and Human Services (including the Centers for Disease Control and Prevention, and the National Institute of Mental Health) to work in the mitigation of rising rates of suicide, depression, PTSD and other adverse behavioral and social health outcomes in our Active Duty, Reserve and National Guard Soldiers, Families, and Retirees. MEDCOM is working with other key organizations to build a robust public health capability in the area of Behavioral and Social Health outcomes (to include suicides and homicides). This effort includes the construction of an Army-level relational database that draws critical information from numerous sources to enable comprehensive analysis of adverse outcomes in Army organizations and communities.

Establishing Successful Interagency Partnerships (National Interagency Biodefense Campus) - Fort Detrick, Maryland hosts and is intimately involved in the development of the National Interagency Biodefense Campus (NIBC) to fill gaps in national biodefense and integrate agencies for a whole of government approach to national security. As a charter member of the National Interagency Confederation for Biological Research (NICBR), a collaboration of the National Cancer Institute along with the NIBC partners, the Army is breaking ground in building on a model for interagency cooperation at Fort Detrick. During 2008, members of the NICBR/NIBC were involved in developing national policy on biodefense and biotechnology, as well as collaborating on research. Research includes work on developing vaccines, diagnostics, forensics, and therapeutics. While focusing on protecting people from disease and bioterrorism, members of the NICBR/NIBC participated in multiple national assessments to prioritize and focus biodefense missions, all while continuing united scientific discovery. During 2009, the NICBR/NIBC will continue to work with Congress and others to define and scope gaps and seams in our Nation's biodefense posture.

In closing, I want to thank this Committee for their terrific support of the Defense Health Program and Army Medicine. I greatly value the insight of this Committee and look forward to working with you closely over the next year. I also want to salute our non-commissioned officers for their professionalism, competence, and leadership—they are truly the backbone of Army Medicine. Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the Warriors and Families that we are most honored to serve.

Army Medicine Strategy Map
January 2009
Mission
- Promote, Sustain and Enhance Soldier Health
- Train, Develop and Equip a Medical Force that Supports Full Spectrum Operations
- Deliver Leading Edge Health Services to Our Warriors and Military Family to Optimize Outcomes
Vision
America's Premier Medical Team Saving Lives and Fostering Healthy and Resilient People
Army Medicine...Army Strong!
Strategic Themes
Maximize Value in Health Services
Provide Global Operational Forces
Build the Team
Balance Innovation with Standardization
Optimize Communication and Knowledge Management
SUSTAIN PREPARE RESET TRANSFORM
ENDS
WAYS
MEANS
Patient/Customer/ Stakeholder
Internal Process
Learning and Growth
Resource
CS 1.0 Improved Healthy and Protected Families, Beneficiaries and Army Civilians
CS 2.0 Optimized Care and Transition of Wounded, Ill, and Injured Warriors
CS 3.0 Improved Healthy and Protected Warriors
CS 4.0 Responsive Battlefield Medical Force
CS 5.0 Improved Patient and Customer Satisfaction
CS 6.0 Inspire Trust in Army Medicine
In Support of
The Army Family Covenant
IP 7.0 Maximize Physical and Psychological Health Promotion and Prevention
IP 8.0 Improve Quality, Outcome-Focused Care and Services
IP 9.0 Improve Access and Continuity of Care
IP 10.0 Optimize Medical Readiness
IP 11.0 Improve Information Systems
IP 12.0 Implement Best Practices
IP 13.0 Build Relationships and Enhance Partnerships
IP 14.0 Improve Internal and External Communication
IP 15.0 Synchronize Army Medicine to Support Army Stationing & BRAC
IP 16.0 Leverage Research, Development and Acquisition
LG 17.0 Improve Recruiting and Retention of AMEDD Personnel
LG 18.0 Improve Training and Development
LG 19.0 Promote and Foster a Culture of Innovation
LG 20.0 Improve Knowledge Management
R 21.0 Optimize Resources and Value
R 22.0 Optimize Effective Management of Facilities and IT Infrastructure
R 23.0 Maximize Human Capital
Feedback Adjusts Resourcing Decisions
This is a dynamic, living document
For more information go to: https://ke2.army.mil/bsc

ARMY MEDICINE
BALANCED SCORECARD (BSC) OVERVIEW

PURPOSE

The Balanced Scorecard strategic management framework has been and continues to serve as the centerpiece of the Army Medicine's enterprise-wide Strategic Management System. The first AMEDD strategy map was approved by LTG James B. Peake on April 2001 and the framework has continued through today with LTG Eric B. Schoomaker's January 2009 strategy map. The BSC is used to drive top-to-bottom organizational understanding and alignment, focus day-to-day efforts, and ensure that we are executing our Mission.

OVERVIEW

The BSC is a concept introduced by Doctors Robert Kaplan and David Norton in 1992. The BSC is a framework to translate the organization's strategy into terms that can be easily understood, communicated, and acted upon (measureable action).

The foundation and main driver of a BSC is the organization's Mission and Vision. Four perspectives then define the organization: Patient/Customer/Stakeholder (Ends), Internal Processes (Ways), Learning and Growth (Means), and Resource (Means). The April 2008 strategy map (one page schematic) describes Army Medicine's strategy via the strategic objectives (located in the bubbles on the strategy map) in each perspective. Behind each strategic objective is a detailed objective statement that clearly defines the meaning of the strategic objective and measure, which will drive behavior to accomplish each objective. Each measure will have a target and supporting initiatives that will drive the change required to allow the organization to move closer to its intended outcomes (ends).

The BSC is a dynamic, living document that will be refined due to mission and priority changes, organizational learning, as well as when targets are met. Periodic reviews are conducted to ensure proactive change.

ORGANIZATIONAL CASCADING and ALIGNMENT

To ensure enterprise-wide alignment to the Army Medicine BSC, Major Subordinate Command Commanders and Corps Chiefs are required to build a supporting BSC and conduct an alignment brief with TSG.

ADDITIONAL INFORMATION

Detailed information, to include the Army Medicine BSC, is located at https://ke2.army.mil/bsc

https://ke2.army.mil/bsc

As of May 09

Not for Publication until released by
The House Armed Services Committee

Statement of

Vice Admiral Adam M. Robinson, MC, USN

Surgeon General of the Navy

Before the

Subcommittee on Military Personnel

of the

House Armed Services Committee

Subject:

The State of Navy Medicine

15 May 2009

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the House Armed Services Committee

Chairwoman Davis, Congressman Wilson, distinguished members of the committee, since I testified last year we have seen the emergence of impressive changes and unique challenges to this nation and the global community. A historic Presidential election which has made significant national and international political impact, a war effort sustained with military troops deploying into hostile areas; and an increasing military medicine presence playing a key role to support the humanitarian civil assistance mission. We are seeing uncertainty, change and fluctuation in our economy that will impact all of us, including military medicine.

Navy Medicine continues on course, because our focus has been, and will always be providing the best healthcare for our Sailors, Marines, and their family members while supporting the Chief of Naval Operations' Maritime Strategy. We are focused on strengthening Navy Medicine today, and are proactively planning to meet future healthcare requirements.

Navy Medicine is built on a solid foundation of proud traditions and a remarkable legacy of Force Health Protection. Our focus has not changed and every day in Navy Medicine we are preparing healthy and fit Sailors and Marines to protect our nation and be ready to deploy.

Navy Medicine is playing a major part in supporting the Maritime Strategy. You will find us at home and around the world providing preventive medical care; health maintenance training and education; direct combat medical support; medical intelligence; and operational planning mission support. Our Navy Medicine teams are flexible enough to participate in Overseas Contingency Operations, a homeland defense mission, a humanitarian civic assistance mission, and a disaster relief mission; while at the same time provide direct health care to our nation's heroes and their family members at home and overseas.

In spite of all of the missions we are currently prepared to participate in, we are continuously making the necessary changes and improvements to meet the requirements of the

biggest consumer of our operational support efforts -- the Marine Corps. Currently, we are realigning medical capabilities to support operational forces in emerging theaters of operation. Since the global operations to combat terrorism began, Navy Medicine's combat medical support has proven exceptionally successful at bringing wounded service members home. We hope, through our ability to remain agile and flexible, to sustain those efforts -- like the record-high survivability rates -- and improve them wherever possible.

The Navy's Maritime Strategy calls for proactive humanitarian civic assistance and disaster response efforts. These missions have been taking place since 1847, and have come a long way since then. The Navy's Humanitarian Civil Assistance missions are now pre-planned engagements deployed from sea-based, land-based or expeditionary platforms to meet a great spectrum of medical needs. From basic medical evaluation and treatment, to optometry, to general surgery, and immunizations, our physicians, nurses, dentists, ancillary healthcare professionals, and hospital corpsmen are ready.

Our efforts have continued to grow and this year, the U.S. Southern Command will sponsor four multi-service Medical Readiness Training Exercises (MEDRETEs). These missions will visit Jamaica, Honduras, the Dominican Republic and Guyana and will include a Navy Medicine Reserve Component. These two-week deployments will provide primary care in remote locations in conjunction with the Ministry of Health of each host nation. The medical services provided will include preventive medicine education, pediatrics, primary medical care, immunizations, pharmacy services, and dental care.

Over 400 Navy Medicine personnel are ready to provide humanitarian civil assistance later this year in two ship-based missions. In April, the USNS COMFORT (TAH 20) deployed for a 120-day mission in support of United States Southern Command to South and Central

America as part of Continuing Promise 09. Later in 2009, in support of the United States Pacific Command, the USS DUBUQUE (LPD 8) will deploy for a 125-day mission as part of Pacific Partnership 09.

Our nation's humanitarian efforts serve as a unique opportunity to positively impact the perception of the United States and our allies by other nations. These often joint missions serve as examples of how increased collaboration between host nations, the other services, other government agencies, and non-governmental organizations can maximize available resources in order to improve worldwide response capability. From our experience, we have developed a successful model of healthcare education and training for host country providers. This will lead to local sustainable activities that will provide long-lasting benefits to help overcome healthcare barriers in resource poor countries. Furthermore, these missions have become another avenue for improved recruiting and retention of Navy Medicine healthcare providers.

While our humanitarian civil assistance missions provide us with some amazing opportunities as providers of medical care, Navy Medicine is acutely aware and incredibly proud of our operational commitment to the United States Marine Corps. We never stop improving our strategic ability, operational reach, and tactical flexibility. As the Marine Corps forces shift their efforts to Afghanistan, Navy Medicine will be there providing the highest quality combat medical support from the corpsmen who stand by their Marines on the battlefield, to expeditionary medical facilities, to the care provided at a military hospital and world-class restorative and rehabilitative care facilities in the continental U.S.

We continue to make improvements to meet the needs of Sailors and Marines who may become injured – while serving in theater or training at home. Over the last year, Navy Medicine significantly expanded services so that wounded warriors would have access to timely,

high-quality medical care. Our response is two-tiered, first to uncompromisingly increase specialized multidisciplinary teams, and second, to expand sharing with other government agencies and the private sector of clinical resources, research and expertise.

In addition, Navy Medicine's Concept of Care is always patient and family focused. We never lose our perspective in caring for all our beneficiaries – everyone is a unique human being in need of individualized, compassionate, and professionally superior health care. At our military treatment facilities (MTFs), we recognize and embrace the military culture and incorporate that into the healing process. Based on the progress in a patient's care and healing, from initial care to rehabilitation and life long medical needs, we determine the best clinical location and treatment plan for that patient. Families are a critical part of the health care delivery team, and we integrate the family's needs into the healing process as well.

In 2008, the Bureau of Medicine and Surgery (BUMED), Headquarters for Navy Medicine, consolidated all wounded, ill and injured warrior healthcare support, with the goal of establishing global policy, implementation guidance, and oversight in order to deliver the highest quality customer-focused, comprehensive and compassionate care to service members and their families.

As of April 2009, 168 Medical Care Case Managers were assigned to 45 MTFs and ambulatory care clinics caring for approximately 1500 Operation Enduring Freedom/Operation Iraqi Freedom casualties. The Medical Care Case Managers collaborate with Navy Safe Harbor and Marine Corps Wounded Warrior Regiment in working directly with wounded warriors, family, caregivers and the multi-disciplinary medical team to coordinate the complex services needed for improved health outcomes.

The BUMED Wounded Warrior Regiment Medical Review team and the Returning Warrior Workshop support Marines and Navy Sailors, Reservists and their families by focusing on key issues faced by personnel during their transition from deployment to home. Navy and Marine Corps Liaisons at MTFs aggressively ensure that orders and other administrative details, such as extending reservists, are completed.

Traumatic Brain Injury (TBI) is considered the signature wound of OIF/OEF, due to the proliferation of improvised explosive devices (IED). Navy Medicine continues to improve methods to identify and treat TBI. The traumatic stress and brain injury programs at National Naval Medical Center (NNMC) Bethesda, Naval Medical Center San Diego (NMCSD), Naval Hospital Camp Pendleton (NHCP), and Naval Hospital Camp Lejeune (NHCL) are collaborating to identify and treat service members who have suffered blast exposure. Navy Medicine has partnered with the Navy and Marine Corps community to identify specific populations at risk for brain injury such as front line units, SEALS, and Navy Explosive Ordnance disposal units. Navy Medicine also expanded social work assets to provide clinical mental health support in theater, at Navy MTFs and at regional treatment centers.

Much attention has been focused on ensuring service members' medical conditions are appropriately addressed on return from deployment. The Pre-Deployment Health Assessment (Pre-DHA) is one mechanism that is used to identify physical and psychological health issues prior to deployment. The Post Deployment Health Assessment (PDHA) and the Post Deployment Health Re-Assessment (PDHRA) identify deployment related healthcare concerns on return to home station and 90-180 days post deployment.

Navy Medicine's innovative Deployment Health Centers (DHCs) – currently 17 in high Fleet and Marine Corps concentration areas – support the deployment health assessment process and

serve as easily accessible non-stigmatizing portals for mental health care. The centers are staffed with primary care and mental health providers to address deployment-related health issues such as TBI, Post Traumatic Stress Disorder (PTSD), and substance misuse. Since their establishment in FY07, the DHCs have accomplished over 150,000 healthcare encounters, with approximately 23% for psychological health issues. Approximately 15% of Navy and Marine Corps Post Deployment Health Assessments result in a medical referral, while the Post Deployment Health Re-Assessment medical referral rate is approximately 22%.

Navy Medicine's partnership with the Department of Veterans Affairs (VA) medical facilities continues to be a mutually beneficial partnership. This coordinated care for our warriors who transfer to or are receiving care from a VA facility ensures their needs are met and their families concerns are addressed. Full-time VA staff members are located at several Navy MTFs where they focus on the healthcare needs of service members and their families.

Filling vacancies in the Medical, Dental, Nurse and Medical Service Corps of the Active and Reserve Components is critical in meeting our mission of maintaining medical readiness of the warfighter and providing healthcare to all eligible beneficiaries. My goal is to maintain the right workforce to deliver medical capabilities across the full range of military operations through the appropriate mix of accession, retention, education and training incentives. Working closely with the Chief of Naval Personnel, medical recruiting continues to be one of my top priorities for fiscal year 2009.

Navy Medicine not only equips and trains our current health care professionals; we also prepare the next generation of health care professionals for the challenges ahead. To build the future force for Navy Medicine we must reach out to America's students and young professionals, inviting them to visit our schoolhouses, hospitals, and research facilities so they can see, firsthand, the great opportunities available within Navy Medicine.

We thank Congress for their generous support of our medical special pay and bonus authorities. Although the Critical Wartime Skills Accession Bonus (CSWAB) achieved limited success attracting physicians and dentists in fiscal year 2008, we have made some adjustments to better position ourselves in fiscal year 2009, including increasing CSWAB and allowing multi-year payouts.

Navy Medicine offers one of the most generous and comprehensive scholarships in the healthcare field. The Armed Forces Health Professions Scholarship Program (HPSP) provides tuition assistance for up to four years of school. In addition all professional school required fees and expenses, books and equipment are paid for by the Navy. The value of this program could be well over $200,000 during the course of a four year professional school program. Graduates joint the Navy's active duty healthcare team as commissioned officers. During fiscal year 2008, the Navy Medical and Dental Corps met its HPSP goal for the first time in several years.

In spite of the successes in HPSP Medical and Dental Corps recruitment, meeting our direct accession mission may remain a challenge. The Medical Services Corps is our most diverse Corps with 31 specialties under three general groupings consisting of clinicians, health care administrators, and research scientists.

I anticipate increased demand for Medical Service Corps personnel with respect to Individual Augmentation missions supporting the current mission in Iraq and the increasing role of the military in Afghanistan, planned Humanitarian Assistance and unexpected disaster relief missions, as well as to meet the needs of Marine Corps manning increases and the many wounded warrior programs they support. These demands will impact Medical Service Corps specialties linked to mental, behavioral and rehabilitative health and operational support, such as Clinical Psychologists, Social Workers, Occupational Therapists, Physician Assistants and Physical Therapists.

While it is anticipated that the Assistant Secretary of Defense, Health Affairs' guidance for recruiting and retention incentives for Clinical Psychologists, Social Workers, and Physician Assistants will be released this fiscal year, similar incentives may need to be expanded to other specialties where limited incentives currently exist. Consistent with increased operational demand signals, as well as to compensate for prior shortfalls in recruiting, the overall recruiting goals for uniformed Medical Services Corps officers have nearly doubled since fiscal year 2007.

The Navy has been successful during the past year recruiting and retaining Nurse Corps officers using a combination of accession, retention, and loan repayment incentives. Over 4,000 active duty and reserve Navy nurses are serving in operational, humanitarian, and traditional missions at home and overseas. These men and women are essential to Navy Medicine's Force Health Protection mission. Navy nurses, in particular the wartime nursing specialties of mental health, nurse anesthesia, critical care, family nurse practitioners, emergency medicine, preoperative and surgical care, have been exemplary in all theaters of operations and healthcare settings.

For the first time in over five years, Navy Nurse Corps officer gains in 2008 outpaced losses. Despite the growing national nursing shortage and the resistance of the civilian nursing community to the recession, the recruitment and retention of nurses continues to improve. Additional requirements will be placed on the recruiting and retention efforts of the Nurse Corps in the near future as nursing billets are restored due to changes in the Military to Civilian Conversion program. Future success in the recruitment and retention of nurses will continue to be dependent on incentive packages that are competitive with the civilian sector.

Like recruiting and retention, our Graduate Medical Education (GME) is a critical part of the foundation for Navy Medicine's ongoing success. Navy Medicine provides world-class graduate medical education at nine sites with 60 programs involving over 1000 trainees. Despite the demands on faculty and staff for operational support, our Navy GME programs continue to be highly rated by the Accreditation Council for Graduate Medical Education. Navy program graduates continue to pass their board certification examinations at rates significantly higher than the national average in almost every specialty. More importantly, Navy-trained physicians continue to prove themselves to be exceptionally well prepared to provide care in austere settings ranging from the battle field to humanitarian assistance and disaster relief efforts.

Along with our successes, Navy GME is facing challenges. Advances in medicine and technology are resulting in longer, and in some cases, completely new types of training that stress the fixed number of funded positions available. Additionally, we did not meet medical student accession goals three and four years ago, and this is beginning to impact our current GME programs. The lower number of uniformed graduates will challenge our ability to support our operational health care mission while placing an adequate number of graduates into training to meet our need for specialists in the future.

Navy Medicine scientists conduct basic, clinical, and field research directly related to current and future military requirements and operational needs. In today's unsettled world, we face not only the medical threats associated with conventional warfare, but also the potential use of weapons of mass destruction and terrorism against our military forces and our citizens at home and overseas and our allies. Navy Medicine's research efforts focus on finding solutions to traditional battlefield medical problems such as bleeding, TBI, combat and operational stress, and naturally occurring infectious diseases; as well as the health problems associated with non-conventional weapons including thermobaric blast, biological agents, and radiation.

The DoD Center for Deployment Health Research at the Naval Health Research Center reported that 8.7 percent of U.S. troops who were deployed and exposed to combat duty in Iraq or Afghanistan reported symptoms of PTSD on a screening survey. We anticipate that this ongoing research will prove helpful in identifying populations at especially increased risk of PTSD from combat, and lead to improved diagnosis and prevention strategies.

The Naval Institute for Dental and Biomedical Research helped to prove the military utility of a new product "Dent Stat," a temporary dental filling material used in treating dental emergencies in all forward deployed settings. This user-friendly temporary restorative material helps stabilize and reduce pain from fractured teeth and lost or broken fillings so warfighters can quickly return to their units.

The Navy Medical Research Center developed an updated vaccine against Japanese encephalitis (JE) allowing for U.S. Food and Drug Administration licensure. The JE vaccine should prevent this mosquito-borne potentially fatal brain infection, and will save lives of military personnel who deploy to the Asia-Pacific region, and also civilian travelers to JE-endemic regions.

These are just a few examples of how Navy Medicine's biomedical and dental research, development, testing and evaluation, including clinical investigations, will protect and improve the health of those under our care.

It is important to recognize the unique challenges before Navy Medicine at this particularly critical time for our nation. Growing resource constraints for Navy Medicine are real, as is the increasing pressure to operate more efficiently without compromising healthcare quality and workload goals. The Military Healthcare System (HMS) continues to evolve, and we are taking advantage of opportunities to modernize management processes that will allow us to operate as a stronger innovative partner within the MHS.

As you heard from me a few weeks ago, integration of care between the military direct care and our civilian network, and across the services, has implications related to both the quality and cost of care. The National Capital Area and the San Antonio military markets have become pilots for a "joint" healthcare system. While the models are different, the end goal is the same: a single approach to healthcare. With the current economic situation driving the need for cost effectiveness, movement toward a Unified Medical Command construct will likely accelerate. Identifying those functions that can be joint -- along with those that need to remain service specific -- is a critical component of the success of the project. Bringing the direct care system and the TRICARE Management Activity under a single command structure offers significant advantages and might be the next best step as military healthcare evolves. Navy Medicine supports and is actively engaged in these efforts.

Chairwoman Davis, Ranking Member Wilson, I want to express my gratitude on behalf of all who work for Navy Medicine – uniformed, civilian, contractor, volunteer personnel – who are committed to meeting and exceeding the health care needs of our beneficiaries. Thank you

again for providing me this opportunity to share with you Navy Medicine's mission, what we are doing today, and our plans for the future. It has been my pleasure to testify before you today and I look forward to answering any of your questions.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON ARMED SERVICES

SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: FY10 Defense Health Program Overview

STATEMENT OF: Lieutenant General (Dr.) James G. Roudebush
Air Force Surgeon General

May 15, 2009

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) JAMES G. ROUDEBUSH

Lt. Gen. (Dr.) James G. Roudebush is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Roudebush serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Roudebush has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of more than 43,100 people assigned to 75 medical facilities worldwide.

The general entered the Air Force in 1975 after receiving a Bachelor of Medicine degree from the University of Nebraska at Lincoln, and a Doctor of Medicine degree from the University of Nebraska College of Medicine. He completed residency training in family practice at the Wright-Patterson Air Force Medical Center, Ohio, in 1978, and aerospace medicine at Brooks Air Force Base, Texas, in 1984. The general commanded a wing clinic and wing hospital before becoming Deputy Commander of the Air Force Materiel Command Human Systems Center. He has served as Command Surgeon for U.S. Central Command, Pacific Air Forces, U.S. Transportation Command and Headquarters Air Mobility Command. Prior to his selection as the 19th Surgeon General, he served as the Deputy Surgeon General of the U.S. Air Force.

EDUCATION

1971 Bachelor of Medicine degree, University of Nebraska at Lincoln
1975 Doctor of Medicine degree, University of Nebraska College of Medicine
1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar
1989 Institute for Federal Health Care Executives, George Washington University, Washington, D.C.

1992 National War College, Fort Lesley J. McNair, Washington, D.C.
1993 Executive Management Course, Defense Systems Management College, Fort Belvoir, Va.

ASSIGNMENTS
1. July 1975 - July 1978, resident in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
2. July 1978 - September 1982, physician in family practice and flight surgeon, USAF Hospital, Francis E. Warren AFB, Wyo.
3. October 1982 - July 1984, resident in aerospace medicine, USAF School of Aerospace Medicine, Brooks AFB, Texas
4. August 1984 - September 1986, Chief of Aerospace Medicine, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
5. September 1986 - July 1988, Commander, USAF Clinic, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
6. August 1988 - June 1991, Commander, 36th Tactical Fighter Wing Hospital, Bitburg Air Base, Germany
7. August 1991 - July 1992, student, National War College, Fort Lesley J. McNair, Washington, D.C.
8. August 1992 - March 1994, Vice Commander, Human Systems Center, Brooks AFB, Texas
9. March 1994 - January 1997, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
10. February 1997 - June 1998, Command Surgeon, Pacific Air Forces, Hickam AFB, Hawaii
11. July 1998 - July 2000, Commander, 89th Medical Group, Andrews AFB, Md.
12. July 2000 - June 2001, Command Surgeon, U.S. Transportation Command and Headquarters Air Mobility Command, Scott AFB, Ill.
13. July 2001 - July 2006, Deputy Surgeon General, Headquarters U.S. Air Force, Bolling AFB, Washington, D.C.
14. August 2006 - present, Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION
Rating: Chief flight surgeon
Flight hours: More than 1,100
Aircraft flown: C-5, C-9, C-21, C-130, EC-135, F-15, F-16, H-53, KC-135, KC-10, T-37, T-38, UH-1 and UH-60

BADGES
Chief Physician Badge
Chief Flight Surgeon Badge

MAJOR AWARDS AND DECORATIONS
Distinguished Service Medal
Defense Superior Service Medal with oak leaf cluster
Legion of Merit with oak leaf cluster
Meritorious Service Medal with two oak leaf clusters
Air Force Commendation Medal
Joint Meritorious Unit Award
Air Force Outstanding Unit Award with oak leaf cluster
National Defense Service Medal with bronze star
Southwest Asia Service Medal with bronze star
Air Force Overseas Long Tour Ribbon with oak leaf cluster
Air Force Longevity Service Award with silver oak leaf cluster
Small Arms Expert Marksmanship Ribbon
Air Force Training Ribbon

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS
Society of USAF Flight Surgeons
Aerospace Medical Association
International Association of Military Flight Surgeon Pilots

Association of Military Surgeons of the United States
Air Force Association
American Medical Association

EFFECTIVE DATES OF PROMOTION
Second Lieutenant May 15, 1972
First Lieutenant May 15, 1974
Captain May 15, 1975
Major Dec. 8, 1979
Lieutenant Colonel Dec. 8, 1985
Colonel Jan. 31, 1991
Brigadier General July 1, 1998
Major General May 24, 2001
Lieutenant General Aug. 4, 2006

(Current as of May 2008)

Madame Chairwoman, Representative Wilson and esteemed members of the Committee, it is my honor and privilege to be here today to talk with you about the Air Force Medical Service. Our Air Force medics work directly for the Line. To that end, we too are focused on reinvigorating the Air Force nuclear enterprise; partnering with the joint and coalition team to win today's fight; developing and caring for Airmen and their families; modernizing our Air and Space inventories, organizations, and training, and, recapturing acquisition excellence.

In support of our Air Force priorities, our Air Force Medical Service (AFMS) is on the cutting edge of protecting the health and well-being of our Service men and women everywhere. Our experience in battlefield medicine is shaping America's health care for the 21st Century and beyond. We are actively enhancing readiness; ensuring a fit, healthy force, and building/sustaining the model health system for the Department of Defense (DoD). In short, it's a great time to be in Air Force medicine!

ADVANCEMENTS IN READINESS

Air Force medics contribute significant capability to the joint warfight in aeromedical evacuation, combat casualty care and wartime surgery. Our advancements in these areas are unparalleled in previous combat experience.

Our Critical Care Air Transport Teams (CCATTs) provide unique "Intensive Care Unit (ICU) care in the air" within DoD's joint enroute medical care system. We continue to improve the outcomes of CCATT wounded warrior care by incorporating lessons learned into clinical practice guidelines and modernizing equipment to support the mission. For example, we are developing a joint electronic in-flight patient medical record to ensure effective patient care documentation and record availability. We are working to improve CCATT equipment, such as

mobile oxygen storage tanks and airborne wireless communication systems, and continuing to evaluate existing equipment to ensure safety for our patients.

On the ground, at both the Air Force Theater Hospital at Balad, Iraq and Craig Joint Theater Hospital at Bagram, Afghanistan, Air Force medics lead numerous combat casualty care initiatives that will positively impact combat and peacetime medicine for years to come. The Air Force surgeons garnered invaluable experience in the field of vascular surgery that laid the foundation for a state-of-the-art endovascular operating room at Balad--the only DoD facility of its kind. The inaugural use of diagnostic angiography and vena caval filters, along with coil embolization and stent grafts in select vascular surgeries in-theater have truly modernized care of our joint warfighter and coalition casualties. Colonel (Dr.) Jay Johannigman, the 332nd Expeditionary Medical Operations Squadron lead trauma surgeon, said, "Our Joint combat hospitals, be they Army, Navy, or Air Force, are all beginning to think alike and do things similarly. These efforts help us improve and speed the care to the patient."

Working with the Armed Services Blood Program Office, Air Force medics have improved the supply of crucial life-saving blood products in-theater, supplementing fresh blood with a new frozen red blood cell product with an extended shelf life. An in-theater apheresis center was established to collect fresh platelets needed to support aggressive treatment of trauma patients requiring massive transfusions.

The ability to collect and analyze data is critical to our success in combat casualty care. The Joint Theater Trauma Registry (JTTR), established in 2004, has made significant strides in these efforts. Their work led to major changes in battlefield care, including management of extremity compartment syndromes, burn care resuscitation, and blood transfusion practices. Their results are setting military-civilian benchmarking standards. The JTTR is truly a joint

effort, with full participation of the Air Force. An Air Force physician is the JTTR system deputy director, and our critical care nurses are key players in the in-theater JTTR team. Through the JTTR we're capturing and implementing best practices for management of the extensive trauma cases seen.

Air Force-unique expertise pays dividends back home, as well as in theater, and is saving lives. Many Americans who have become victims of natural disasters benefited from our humanitarian support. When Hurricanes Katrina and Rita struck in 2005, Air Force Active Duty, Guard, and Reserve medics were in place conducting lifesaving operations. Similarly, hundreds of members of this Total Force team were in place September 1, 2008 when Hurricane Gustav struck the Louisiana coast and when Hurricane Ike battered Galveston, Texas, less than two weeks later. During Hurricane Gustav, Air Mobility Command coordinated the movement of more than 8,000 evacuees, including 600 patients. Aircrews transported post-surgery/post-intensive care unit patients from Galveston area hospitals to Dallas medical facilities. I am extremely proud of this incredible team effort.

ENSURING A FIT AND HEALTHY FORCE

The success of our medical readiness mission directly correlates with our ability to build and maintain a fit and healthy force at home station and in-theater. One way we do this is through optimization of health care delivery. Our Family Health Initiative, our Air Force "medical home," optimizes health care practice within our family health clinics, increasing the number of medical technicians on the family health teams to better accommodate the enrolled population and streamlining the processes for care and disease management.

We achieve a fit and healthy force by measuring our health care outcomes. The AFMS has used the Healthcare Effectiveness Data and Information Set measures for more than eight

years to assess the care we deliver. Our outcome measures for childhood immunization delivery, asthma medication management, LDL cholesterol control in diabetics, and screening for Chlamydia all exceed the 90th percentile in comparison to civilian benchmarks. We also compare very highly with civilian hospital care for all 40 of our measures developed by the Agency for Healthcare Research and Quality, which evaluates patient safety, inpatient quality, pediatric care quality, and prevention-related quality for our hospital services. We recently began measuring 30-day mortality rates for myocardial infarction, pneumonia and congestive heart failure, and found that the AFMS is well below the national benchmark in all three measures. In 2009, we will implement measurement of well-child visits and follow-up after mental health hospitalization. While this is all good news, we must remain vigilant in analyzing and evaluating the effectiveness of our health care delivery – our patients deserve the very best.

The exposure of our Airmen to battlefield trauma puts psychological health at the forefront of our health and fitness mission. To mitigate their risk for combat stress symptoms and possible mental health problems, our Landing Gear program takes a proactive approach with education and symptom recognition, both pre- and post-deployment. We educate our Airmen that recognizing risk factors in themselves and others, along with a willingness to seek help, is the key to effectively functioning across the deployment cycle and reuniting with their families.

We have over 600 Active Duty and over 200 civilian and contract mental health providers. This includes 97 additional contract Mental Health providers we added in 2007 to manage increased workload. This mental health workforce has been sufficient to meet the demand signal that we have experienced to date. That said, we do have challenges with respect to Active Duty psychologist and psychiatrist recruiting and retention, and we are

pursuing special pays and other initiatives to try to bring us closer to 100% staffing in those two specialties. We continually assess and reassess the demand based on mission requirements as well as the need for clinical services. We are seeing a gradual increase in the incidence of post-traumatic stress disorder (PTSD) in our Airmen and we are also seeing a persistent demand at the 1:2 dwell rate for mental health providers in the deployed environment. This demand is not likely to decrease, and could well increase over time. We are tracking this demand closely to ensure that we have the resources to meet tomorrow's demand.

With regard to what we are doing about PTSD, we address post-traumatic stress (PTS) in our Airmen by combining resilience training with frequent screening and ready access to mental health care. Resilience training is conducted via an Air Force developed program Landing Gear, where Airmen learn what to expect while deployed, and when and how to get help for stress symptoms. Screening occurs before deployment, at the end of deployment, 90-180 days post-deployment and annually via the Physical Health Assessment. Each screening asks about PTS and other psychological symptoms. Health care providers fully assess all symptoms noted on the screening, and refer to mental health providers for further care as needed. We also train frontline supervisors and have positioned mental health personnel in our primary care clinics in order to increase access and reduce stigma. Quality health care for our Airmen requires our mental health providers to have the best tools available to treat PTS. To that end, we have sent 490 of our mental health providers to 2- and 3-day workshops conducted by civilian subject matter experts on the two widely recognized methods of PTSD treatment. All our providers, mental health and primary care, are trained and follow nationally approved DoD/Veterans Affairs (VA) clinical practice guidelines to ensure that all treatment for PTSD is state of the art and meets the highest standards.

For your awareness, 1,758 Airmen have been diagnosed with PTSD within 12 months of return from deployment (Fiscal Year 2002-Fiscal Year 2008). The vast majority of these Airmen continued to serve with the benefit of treatment and support. Of these Airmen, 255 have enrolled in our Wounded Warrior program secondary to PTSD, and are not expected to return to duty. Our efforts at early PTS identification and treatment strive to maximize the number of Airmen we are able to return to full duty and health. As noted, however, we are seeing an increase over time in the number of our Airmen with diagnosed PTSD.

Understanding that suicide prevention lies within and is integrated into the broader construct of psychological health and fitness, we continue to aggressively work our eleven suicide prevention initiatives, which include frontline supervisor training and suicide risk assessment training for mental health providers. We have mental health providers in our family health units to provide the full spectrum of care for both our active duty and family members. This allows us to approach issues in a way conducive to quick recognition and resolution, while reducing any perceived stigma associated with visits to mental health clinics. Suicide prevention requires a total Air Force community effort, using all tools available. We are expanding our ability to identify, track and treat Airmen dealing with PTSD, Traumatic Brain Injury (TBI), or other mental health problems to ensure no one is left behind who needs help. We have the resources, the opportunity, and clearly the need to better understand, and care for these injuries.

Current treatment/management for TBI is based on Defense and Veterans Brain Injury Center (DVBIC) TBI Clinical Guidance. The Air Force TBI treatment is done by a multidisciplinary team guided by comprehensive brain injury and mental health assessment tools. All TBI patients receive education on TBI symptoms and management as well as

appropriate referrals for occupational therapy, physical therapy, speech and language, pharmacy, audiology and optometry. Cognitive rehabilitation is initiated after medical issues have subsided and the patient's pain is managed. In Fiscal Year 2009, video teleconferencing equipment will be installed in all mental health clinics to allow direct consult with the DVBIC.

We have also taken the lead in DoD with diabetes research and community outreach. We have a very productive partnership with the University of Pittsburgh Medical Center (UPMC) and the Army. Wilford Hall Medical Center (WHMC), Lackland AFB, Texas, is designated as the initial DoD roll-out site for diabetes initiatives developed at UPMC. Major Mark True, an endocrinologist, is the WHMC project lead and director for the Air Force diabetes program. He established a Diabetes Center of Excellence (DCOE) program and, in August 2007, introduced several inpatient diabetes protocols and initiatives in the hospital, including an intravenous insulin protocol that substantially improved glucose control in critical care units. We are working to open an outpatient regional DCOE that will impact clinical outcomes across a regional population. This will be supported by the Mobile Diabetes Management with Automated Clinical Support Tools project beginning this year, which will demonstrate improved diabetic management through cell phones and web-based technology use.

BUILDING AND SUSTAINING A PRE-EMINENT AFMS

Sustaining the AFMS as a premiere organization requires the very best in education and training for our professionals. In today's military, that means providing high quality programs within our system, as well as strategically partnering with academia, private sector medicine and the VA to assure that our students, residents and fellows have the best training opportunities possible.

With the ongoing demand for well trained surgeons in our trauma care mission, we have focused on Surgical Care Optimization. This initiative identified eleven medical treatment facility (MTF) platforms to provide the capacity necessary to keep critical wartime medics proficient in battlefield trauma care. It also seeks to increase MTF recapture of DoD beneficiary specialty care by optimizing operating room access and efficiency.

Our Graduate Medical Education programs consistently graduate residents fully prepared to provide excellent clinical care in the inpatient, outpatient and deployed settings. The outstanding performance of our residents on board certification exams is just one marker of the success of our numerous training programs, many of which are partnered with leading civilian institutions throughout the country, including Wright State and Cincinnati University in Ohio; Saint Louis University in Missouri, and the Universities of Mississippi, Texas, Nevada and California.

We partner with local civilian medical facilities to support the Sustainment of Trauma And Resuscitation Skills Program, enabling home-station clinical currency rotations in private sector level one trauma centers. Our Centers for Sustainment of Trauma and Resuscitation Skills is an immensely successful partnering endeavor that provides immersion trauma skills training with some of the great trauma centers in the Nation – R. Adams Cowley Shock Trauma Center in Baltimore, Maryland; University Hospital in Cincinnati, Ohio; and St. Louis University Medical Center, Missouri. Nearly 800 physicians, nurses and technicians completed this training in 2008; many of them deployed soon after and reported being very well prepared for their roles in combat medicine.

Working closely with our Department of Veterans Affairs partners, we continuously strive to streamline the system for all our personnel to include our wounded, ill and injured Airmen. A major success in this partnership is our joint ventures. The Air Force has four of the eight existing DoD/VA joint venture sites – Elmendorf AFB, Alaska; Kirtland AFB, New Mexico; Nellis AFB, Nevada; and Travis AFB, California. Three additional sites are under consideration or in development at Keesler AFB, Mississippi; Buckley AFB, Colorado; and Eglin AFB, Florida. These joint ventures offer optimal health care delivery capabilities for both our patient populations, while also serving to make the most of taxpayer dollars.

The Disability Evaluation System pilot program is a joint effort that resulted from the Commission on Care for America's Returning Wounded Warriors. The goal is to simplify health care and treatment for injured Service members and veterans and to deliver benefits as quickly as possible. Malcolm Grow Medical Center at Andrews AFB, Maryland was one of the initial three military medical treatment facilities in the National Capital Region to participate. The pilot streamlined and increased transparency of both the medical examination board process and the VA disability and compensation processes. In the pilot, both processes now occur concurrently, provide more information for the member during the process, and supply comprehensive information regarding entitlements from both agencies at the time of the separation. Continued evaluation of the study is slated to occur at 19 more military installations, to include Elmendorf AFB, Alaska.

Cutting-edge research and development initiatives are critical to building the future AFMS. The Virtual Medical Trainer is a continuation of existing efforts to develop advanced distributed learning. This project focuses on the development of training for disaster preparedness and medical care contingencies, addressing such areas as equipment, logistics,

and war readiness skills training. Extensive work has been done to increase simulation in all of our hospitals and trauma training centers. Shared simulation with our university partners improves care and patient safety for both civilian and military patients. Virtual or simulation capabilities are a very cost-effective way to train and prepare our medics to do a variety of missions.

Keesler AFB, Mississippi is studying advanced technologies to include robotic microscopy and virtual (whole slide) imaging. Eight MTFs have the robotic microscopes, and efforts are underway to obtain connectivity between MTFs and the VA Medical Center at Omaha, Nebraska. Once fully operational, this system allows general clinicians remote access to expert advice, diagnosis, and mentoring, and provides high quality standard of care independent of location.

Similarly, telemedicine is vastly expanding the capabilities of our existing resources. Wright-Patterson AFB, Ohio, radiologists and clinicians are successfully providing consultation services across the Air Force, and this year the project is slated to extend to Landstuhl Army Medical Center, Germany, and RAF Lakenheath, England. Automated Identification and Data Collection, a new business process study at Keesler AFB, Mississippi will identify opportunities for radiofrequency identification and barcode technologies in military medicine. We are exploring how to improve clinical and administrative processes in medical equipment management and repair, patient flow analysis and management, bedside services, medication administration, and surgical tray management.

Successfully building and sustaining the AFMS requires continued focus on the physical plants we occupy to perform our mission. We greatly appreciate the tremendous support you have provided to recapitalize Air Force aging medical infrastructure. We're excited about our

plans to improve facility restoration and sustainment and to move forward with sorely needed medical military construction (MILCON) projects.

Green design initiatives and energy conservation continue to be high priorities for the Air Force. We are incorporating these into AFMS MILCON and restoration projects for our MTFs. We use the nationally accepted benchmark--Leadership in Energy and Environmental Design--to design and construct buildings with sustainable design elements. I'm pleased to share some recent examples, such as exterior solar shading panels used in Keesler AFB's Base Realignment and Closure (BRAC) Tower and Diagnostic Imaging Center projects. A grey water system incorporated into Tinker AFB, Oklahoma MILCON recycles treated wastewater generated from MTF hand-washing for use in toilets or irrigation systems, decreasing or eliminating the amount of fresh water used for those purposes. Our projected Fiscal Year 2010 Air Force MILCON projects will incorporate enhanced day lighting concepts allowing more natural light into buildings and office spaces. Our energy optimization efforts are both environmentally and fiscally beneficial and enable us to better serve military members and their families.

Our most critical building block for the future is our people. With these unprecedented advances in training and research, it is understandable that the Air Force continues to attract many of the finest health professionals in the world. In Fiscal Year 2008, the Air Force Medical and Dental Corps exceeded their Health Professions Scholarship Program (HPSP) recruiting goals. HPSP is our most successful recruiting tool, and we are seeing positive early trends in retention from our other financial assistance programs and pay plans. We are working closely with our personnel and recruiting communities at targeting accession and retention bonus plans to ensure full and effective staffing with the right specialty mix to perform our mission.

BUILDING A JOINT AND EFFECTIVE MILITARY HEALTH SYSTEM

The AFMS is committed to working with our Sister Services to support joint medical capabilities and leverage common operating platforms such as logistics, research and development and information management/information technology. We are well on the way to bringing BRAC plans to fruition. The Joint Task Force National Capital Region Medical, or JTF CapMed, is moving forward with plans to combine the Army, Navy, and Air Force assets into the new Walter Reed National Military Medical Center. Malcolm Grow Medical Center at Andrews AFB, Maryland, is our component to JTF CapMed and serves as an important care delivery platform in the NCR as the east coast hub for aeromedical evacuation. Since late 2001, Andrews AFB has welcomed home and cared for more than 33,000 patients arriving from Operations Enduring Freedom and Iraqi Freedom, U.S. Central Command, U.S. European Command and U.S. African Command.

The BRAC plans are also moving forward in San Antonio, Texas, to integrate Army and Air Force MTFs into the new San Antonio Military Medical Center (SAMMC), creating the largest inpatient facility in DoD. SAMMC has integrated nearly all clinical activities and has led the way in bringing the Air Force and Army together in an integrated platform that meets the Air Force, Army, and joint mission requirements all the while maximizing the use of existing resources.

Also in San Antonio is the Medical Education and Training Campus (METC). This is an important step toward what leaders are calling the largest consolidation of training in the history of the Department of Defense. Upon completion in 2011, the joint campus, led by tri-Service leadership, will centralize all Army, Navy and Air Force basic and specialty enlisted medical

training at Fort Sam Houston, Texas. At Wright-Patterson AFB, Ohio, the 711th Human Performance Wing has been activated and will serve as a cutting-edge joint center of excellence for human performance and aerospace medicine.

These are but some of the ways and places we are working toward joint solutions that enhance mission support and benefit the quality of medical care for our warfighters and their families.

BRIGHT FUTURE AND GOOD TIME TO BE IN THE AIR FORCE MEDICAL SERVICE

Air Force medics make a difference in the lives of Airmen, Soldiers, Sailors, Marines, family members, coalition partners and civilians. They take pride in every patient encounter and earn our Nation's trust...everyday!

As we look to the way ahead, I see a great future for the AFMS, built on a solid foundation of top-notch people, outstanding training programs and strong partnerships. It is indeed an exciting, challenging and rewarding time to be in Air Force medicine! I couldn't be more proud.

We join our Sister Services in thanking you for your enduring support.

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

MAY 15, 2009

RESPONSE TO QUESTION SUBMITTED BY MR. WILSON

Mr. MIDDLETON. Based on the recommendations of the Joint Pathology Center Work Group (JPCWG), the Defense Health Board, and the Senior Military Medical Advisory Committee, the Assistant Secretary of Defense for Health Affairs selected the Joint Task Force National Capital Region Medical's (JTF CapMed's) proposal to establish the federal joint pathology center. JTF CapMed, with input from the JPCWG, developed a concept of operations and an implementation plan for the center. Initial operating capability is targeted for July 2010 and full operating capability is planned by mid-September 2011. [See page 18.]

RESPONSES TO QUESTIONS SUBMITTED BY MS. SHEA-PORTER

Mr. MIDDLETON. Billing and collecting for medical care provided to contractors by deployed medical units in Southwest Asia is being pursued. The January 7, 2007 Office of the Secretary of Defense, Comptroller (OUSD(C)) memorandum established medical billing rates and requested the Military Departments to establish policies for eligibility, billing, and collections for deployed medical or non-fixed medical facilities. A working group, chaired by OUSD(C), is determining roles and responsibilities and developing specific policy for implementing and overseeing a billing process in Southwest Asia. This will include a process to bill for healthcare provided in prior years to contractors. [See page 21.]

General SCHOOMAKER. According to information provided by the Defense Manpower Data Center, since 11 September 2001 the Army has simultaneously deployed over 2800 dual-military couples with dependents. The Army implements the Department of Defense (DoD) policy as it relates to dual-military couples with dependents or single parents deployed into combat zones or imminent danger areas. DoD personnel assignment and deployment policies exist to enhance the capability of the Military Services to meet National Security objectives. Each member similarly qualified takes his or her turn at assignments or deployments to various geographical regions and positions. These assignments and deployments include duty in imminent danger and hostile fire areas or in combat zones, without regard to relationship to other Service members.

The nature of an all-volunteer force shapes our assignment and deployment policies. Our Soldiers voluntarily entered the profession of arms, cognizant of the possibility of assignment to hazardous duty for themselves or any other Family member who may be serving. Entering the military is a voluntary acceptance of the risk that they or a Family member might be killed, disabled, missing in action, or captured while serving in the defense of the Nation. It is this sense of shared sacrifice that helps bind the military together, enhances morale, and is the basis of an effective fighting force.

The underlying principles of equality and voluntary acceptance of the inherent dangers associated with military service form the basis for current Family assignment policy. Currently, there is no specific DoD or Army policy that precludes the assignment or deployment of multiple Family members to combat zones at the same time. This includes both a single parent with custody of children and members of a dual-military couple with Family members. As such, current DoD and Army policy requires that dual-military couples with Family members and single parents with custody of children have an approved Family Care Plan (FCP) on file, which is the means by which Soldiers provide for the care of their Family members when military duties prevent the Soldier from doing so. The plan includes proof that guardians and escorts have been appointed and thoroughly briefed on the responsibilities they will assume during the Soldier's absence. Soldiers without approved plans may be considered for separation from the Service.

While these policies may seem inadequate or harsh, they are not absolute. DoD tempers these policies in an attempt to ensure that no single Family is asked to bear an inordinate share of the burden of armed conflict. The following are examples of relief available:

(1) Existing policy addresses the concurrent assignment of multiple Family members to the same unit or ship. The policy provides for reassignment of all but one

member to a different unit or ship. Approval may not restrict the concurrent assignment to combat zones or imminent danger/hostile fire areas, but would ensure they are not serving in the same unit.

(2) Consideration will be given a request for a combat deferment or exemption based on the Soldier or the Family experiencing severe humanitarian or compassionate problems.

(3) Soldiers who acquire Sole Surviving Son and/or Daughter status are exempt from assignment/deployment to a combat zone or imminent danger/hostile fire area. In addition, if a service member of a Family is killed or dies while serving in a designated hostile fire area, other service members of the same Family shall be exempt, on request, from serving in designated hostile fire areas or if serving in such an area shall be reassigned from there.

(4) A married Soldier who becomes a parent or a sole parent may apply for separation under hardship if evidence exists that the role of the parent and Soldier are incompatible and that the Soldier cannot fulfill his or her military obligation without neglecting the child or children.

The current policy on simultaneous deployments of Family members, the equitable assignment policy, and the built-in exception provisions are longstanding, have proven adequate, and should be retained.

The Army is also taking steps to minimize the impact of deployments on military children. The Family and Morale Welfare and Recreation Command ensures that children of dual-military parents receive priority at all child development centers. Families that serve as guardians for children of deployed parents have been granted access to military commissaries. Resources are made available to families through the Military Child Education Coalition and through Military and Army OneSource, which provide 24/7 toll-free assistance as well as short-term, non-medical counseling options. The Army Medical Command (MEDCOM) has established a Military Child and Adolescent Center of Excellence at Madigan Army Medical Center at Fort Lewis, Washington to promote optimal wellness and resilience in military children and adolescents through direct support of interdisciplinary, integrated systems of care, advocacy, training of staff, oversight and quality assurance, and reduction in stigma. The Center of Excellence is developing a better understanding of the unique impacts of deployment on children. It has facilitated research on the impact of parental combat deployment on children and families and presented research and findings at public forums to increase awareness. MEDCOM is in the process of identifying other sites for expansion of the concept. [See page 28.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

MAY 15, 2009

QUESTIONS SUBMITTED BY MS. SHEA-PORTER

Ms. SHEA-PORTER. I read the following submitted testimony by Allen Middleton, the Acting Principal Deputy Assistant Secretary of Defense for Health Affairs: "With regard to environmental health protection, Service Occupational and Environmental Health specialists routinely monitor air, soil, water, and other aspects of the environment in theater to detect and prevent hazardous exposures before they occur. To date, more than 11,000 environmental samples from Iraq and Afghanistan have been collected and analyzed, and new samples are constantly reassessed. Findings to date indicate a low risk to our Forces for any long-term health effects from environmental exposures." However, U.S. bases throughout Iraq and Afghanistan dispose of large quantities of waste through burning in open pits. Fumes from these pits produce toxins that can present an acute health risk to our Service members, and these toxins include carcinogens like dioxin. The Disabled American Veterans has identified over 200 veterans who say exposure to these burn pits has made them seriously and often chronically ill. I am very concerned about the risks of the continuing use of burn pits for the health of our Service members. This practice would never be allowed in the United States of America. Could you please comment on the Department's plans to address this potentially dangerous situation that could have serious impact on our Service members' heath?

Mr. MIDDLETON. The Department of Defense (DoD) takes its responsibility to protect the health of its personnel seriously and is very aware of the heath concerns relating to burn pit smoke at many of our forward operating bases in Iraq and Afghanistan. The Army, Navy, and Air Force preventive medicine teams have gathered and analyzed more than 17,000 air, water, and soil samples in the U.S. Central Command area of responsibility since the start of Operation Enduring Freedom. The purpose of the monitoring was, and continues to be, determining potential environmental health risks and identifying any hazards requiring mitigation to ensure our personnel are operating in a safe environment.

In 2006-2007, Joint Base Balad was selected for a screening health risk assessment focused on burn pit smoke because it was the largest burn pit in theater and the large number of U.S. Service members that worked and lived close to the emanating smoke. When the health risk assessment began in early 2007, before the currently operating incinerators were in place, 163 air samples were taken and analyzed for 30 different parameters providing over 4,000 data points. The screening health risk assessment, using worst case exposure assumptions (breathing the smoke for 24 hours a day, 7 days a week for up to a year) and conducted in accordance with many of the Environmental Protection Agency methods, indicated the risk of long-term (including cancers) and significant short-term health effects for exposure to those chemicals was unlikely. In February 2008, the Defense Health Board, a Federal independent advisory committee, provided a third party review of the Joint Base Balad Burn Pit Risk Assessment to ensure its methodology was correct and its conclusions valid. This board of medical experts, including university professors and renowned scientists in the fields of epidemiology, preventive medicine, and toxicology determined, "Given the data available, the screening risk assessment provides an accurate determination of airborne exposure levels for Service members deployed to Balad Air Base." They went on to conclude that no significant short- or long-term health risks and no elevated cancer risks should be anticipated among personnel deployed to Joint Base Balad. The DoD continues to closely assess any health hazards that may be associated with the burn pit smoke to ensure that our personnel are not exposed to hazardous agents that present a significant health risk.

Over the past year, U.S. Central Command has made a concerted effort to reduce dependence on burn pits. Currently, 17 solid waste industrial incinerators are operational, including three at Joint Base Balad. Twenty-two incinerators are under construction with completion dates ranging through December 2009. Recycling plastics and aluminum and use of landfills to reduce the amount of solid waste for disposal have been implemented at a number of our bases. Since January 2009, used cooking oils and grease from Joint Base Balad have been sent to a local Iraqi rendering facility, reducing the amount of burned material. Furthermore, there are two haz-

ardous waste and 24 medical waste incinerators operating in Iraq with nine additional medical incinerators in the acquisition process. Despite these measures, we will continue to need burn pits during contingency operations to control wastes and ensure waste does not pose a health hazard nor provide a breeding ground for disease-carrying vectors. To this extent, much effort has gone into locating or relocating pits to remote areas of bases to minimize smoke exposures, training personnel on proper operation of the burn pits, developing and circulating correct operating procedures, and assessing burn pit operations to include corrective actions.

Ms. SHEA-PORTER. As you may know, sexual assaults in Iraq and Afghanistan rose 26 percent from 2007 to 2008. In previous hearings on this issue, we were informed that rape kits were not available at all forward operating bases because there are insufficient personnel to administer the rape kits. What steps are being taken to resolve this issue?

Mr. MIDDLETON. The ability of our providers to take care of rape victims is not hindered by lack of availability of sexual assault forensic examination (SAFE) kits or other medical supplies. However, not all forward operating bases have the capability to conduct a SAFE because of training and other support requirements. Normally, a SAFE is conducted at a Combat Support Hospital located at Division level. However, Level II medical treatment facilities (MTFs) within the Division, when they have properly trained personnel and when approved by the Multi-National Corps-Iraq Surgeon, can also conduct SAFEs. Deployed Sexual Assault Response Coordinators (DSARCs) and Uniformed Victim Advocates (UVAs) arrange for examinations and medical care for victims who make restricted or unrestricted reports of sexual assault in deployed environments. A victim at a Forward Operating Base may require evacuation to a facility where a SAFE can be completed by trained provider. The DSARC or UVA facilitates transport.

To ensure continuity of care at designated MTFs, the facility must meet the following requirements:

(a) SAFE-trained medical provider assigned

(b) Mental health support

(c) Criminal Investigation Division reporting capability

(d) Victim advocacy

(e) Chaplain support

(f) Judge Advocate/Legal support

(g) Appropriate laboratory support

Ms. SHEA-PORTER. As you may know, sexual assaults in Iraq and Afghanistan rose 26 percent from 2007 to 2008. In previous hearings on this issue, we were informed that rape kits were not available at all forward operating bases because there are insufficient personnel to administer the rape kits. What steps are being taken to resolve this issue?

General SCHOOMAKER. The ability of our providers in all operational environments to conduct the victim sexual assault forensic examination (SAFE) is not hindered by lack of availability of a SAFE kit or other medical supplies. Instead, because of their mission and location in theater, not all forward operating bases have the capability to conduct the SAFE.

Normally SAFE care and examination is conducted at the Level III, Combat Support Hospital. However, Level II Medical Treatment Facilities, when approved by the theater Surgeon, can conduct victim SAFE. To ensure continuity of care, designated Level II MTFs must meet the following requirements:

(a) SAFE medical provider assigned

(b) Mental health support

(c) CID reporting capability

(d) Victim advocacy

(e) Chaplain support

(f) Judge Advocate/Legal support

(g) Appropriate laboratory support

Level I facilities (Battalion Aid Stations) are designed to stabilize Soldiers. The focus of these facilities is on resuscitative care and lifesaving interventions. When sexual assault victims present at Level I or Level II facilities without SAFE capacity, the healthcare staff stabilizes the victim, orders priority MEDEVAC to a Level III facility, and monitors the victim until his/her departure.

Ms. SHEA-PORTER. As you may know, sexual assaults in Iraq and Afghanistan rose 26 percent from 2007 to 2008. In previous hearings on this issue, we were in-

formed that rape kits were not available at all forward operating bases because there are insufficient personnel to administer the rape kits. What steps are being taken to resolve this issue?

Admiral ROBINSON. The Bureau of Medicine and Surgery (BUMED) has oversight over all CONUS and OCONUS Military Treatment Facilities (MTF), and ensures sexual assault kits are in stock and available in the event of a sexual assault. CENTCOM (Central Command) has responsibility for the availability of sexual assault kits in the deployed regions of Iraq and Afghanistan. Questions about SAPR in CENTCOM (including availability of kits) should be referred to CENTCOM Surgeon.

BUMED is taking steps to improve the effectiveness of SAPR Navy-wide. The BUMEDINST 6010.11, (SAPR) instruction, was approved by the Surgeon General of the Navy and published in June, 2009. The instruction gives very clear and concise guidance on the process and protocol for care of the sexual assault victim, and on performing an appropriate exam with follow-up. It also provides the information necessary for obtaining sexual assault exam kits.

BUMED has initiated an aggressive training program to ensure widespread training in the sexual assault exam and evidence collection. We have already completed the sexual assault forensic exam (SAFE) training curriculum at the Uniformed Services University of the Health Sciences, Naval Hospital Okinawa, and Naval Hospital Naples; and several Nurses and Physicians have been trained at each facility. Arrangements are being made for training at several other MTFs at this time.

Ms. SHEA-PORTER. As you may know, sexual assaults in Iraq and Afghanistan rose 26 percent from 2007 to 2008. In previous hearings on this issue, we were informed that rape kits were not available at all forward operating bases because there are insufficient personnel to administer the rape kits. What steps are being taken to resolve this issue?

General ROUDEBUSH. Since the Air Force established full-time Sexual Assault Response Coordinator (SARC) positions at primary operating locations within combat areas of interest in 2006, there is no known instance of an inability to provide a Sexual Assault Forensic Examination (SAFE) kit for a victim of sexual assault. As identified in the Air Force previous annual reports to DOD on the Sexual Assault Prevention and Response Program (SAPR), medical functions maintain availability of SAFE kits in the deployed areas. During Fiscal Year 2008, the Air Force had 154 emergency room physicians trained to complete forensic examinations. Emergency physicians are fully qualified to perform sexual assault forensic exams without additional training.

Additionally, for the combat areas of interest, the Air Force Office of Special Investigations field detachments are required to retain SAFE kits on-hand as part of their technical investigative supplies and have secured suitable evidence storage capability for sexual assault cases in Iraq and Afghanistan. The full-time SARCs at Air Force Air Expeditionary Wing (AEW) locations oversee any geographically-separated unit that is attached to a main operating location controlled or hosted by the Air Force. Each deployed location has ensured that SARCs have sufficient supplies and materials to provide assistance to victims of sexual assault. SARCs in the deployed environment utilize trained victim advocates to enhance victim response. Restricted reporting is an option available in the deployed environment and has been utilized by sexual assault victims. Airlift and ground transportation are available and have also been used to assist victims/get victims proper care in a timely manner, to include availability of processing SAFE kits.

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